Health Information Management Department
Release of Information
125 16th Ave East, CSB-1
Seattle, Washington 98112
206-326-3058 phone
206-326-2599 fax

June 9, 2008

Regarding Medical Records of the attached patient:

Dear Requester,

Group Health Cooperative is currently unable to comply with your request for the following reason(s):

	Authorization is not compliant with HIPAA Privacy Rules effective April 14, 2003. For your convenience, I am enclosing a Group Health authorization.
	State law does not allow us to honor authorizations that have expired.
	Authorization submitted is illegible
	Authorization submitted is not dated.
	Authorization submitted does not have a purpose of disclosure.
X	We need to have a current authorization signed and dated by the patient.
	Authorization submitted does not explicitly authorize Group Health Cooperative to release medical information.
	It is unclear exactly who is to receive the information.
	We are unable to identify this patient. Please re-submit request with additional information such as Group Health number and/or another alias for this patient.
	The medical information requested has been destroyed in accord with our documentation retention policy.
	We need patient identifiers (ie. Date of birth, Group Health number, social security number) on the authorization.
	No information for dates or items requested.
	A letter of representation is required. Please re-send the authorization and request letter along with a letter of representation.
	You may have sent the original request to a different Group Health facility. Please resubmit your request to the address or fax number above.
	OTHER:

If you have any questions please contact Release of Information at 206-326-3058 or facsimile 206-326-2599.

Sincerely,

Bao-Uyen Nguyen, RHIA
Release of Information *

GroupHealth

Authorization To Release Health Care Information

Please Print

Full Name (include middle initial)

Chart Base

Previous name if applicable

Date of Birth and Consumer Number

DAY TIME PHONE: _____

I HEREBY REQUEST AND AUTHORIZE THE FOLLOWING RELEASE OF INFORMATION:

INFORMATION TO BE RELEASED BY:

ORGANIZATION: Group Health Centralized Release of Information

ADDRESS: 125 16th Ave E, CSB-1/MR Seattle, WA 98112

Phone: 206-326-3058 Toll free: 1-866-656-4184 Fax: 206-326-2899

(City, State, Zip) PHONE: _____

INFORMATION TO BE RELEASED TO:

NAME: _____

ORGANIZATION: _____

ADDRESS: _____

(City, State, Zip) PHONE: _____

PURPOSE OF DISCLOSURE: ☐ Continuing Care ☐ Legal ☐ Insurance ☐ At Patient Request for Patient Use

Other (explain) _____

GENERAL MEDICAL INFORMATION:

	Dates: From/To		Dates: From/To
☐ Clinic Records	_____	☐ Home Care Records	_____
☐ Lab Results	_____	☐ Hospital Records	_____
☐ Radiology Reports	_____	☐ Skilled Nursing Facility Records	_____
☐ Radiology Films	_____	☐ Other	_____

Date _____ Signature of patient or patient's authorized representative _____ Relationship to patient if not patient

RELEASE REQUIRING SPECIFIC CONSENT:

My initials and signature below authorize the release of health care information relating to testing, diagnosis or treatment for:

_____ HIV/AIDS _____ _____ Mental Health _____

_____ Sexually Transmitted Diseases _____ _____ Alcohol/Drug Abuse _____

_____ Reproductive Care (minors only) _____

MINORS—A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

Date _____ Signature of patient or patient's authorized representative _____ Relationship to patient if not patient

☐ Check if patient is a minor

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) except if I receive health care when the sole purpose of the health care is to create health information for a third party.

I understand that: a) I must revoke my authorization in writing and may do so by completing and signing the Revocation of Authorization form, DM-3523, available at my clinic's business or medical records office; b) If I revoke my authorization, it will not affect any actions already taken by Group Health based upon this authorization; and c) I may not be able to revoke this authorization if the purpose of it was to obtain insurance.

Once Group Health has disclosed health information, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information.

This authorization expires _____(date or event). Authorization will expire in ninety days if not otherwise specified.