Authorization to Release Patient Health Information

FORWARD THIS FORM TO RELEASE OF INFORMATON

Virginia Mason Medical Center
1100 9th Ave Seattle, Wa 98101 M13-ROI ph 206-223-6975 fax 206-223-8885 www.virginiamason.org

Patient Name____ VMMC Medical Record #____________________
Last First Middle Initial

Former Name (if any)________________________________ Date of Birth ______/______/______
Last First Middle Initial

Daytime Telephone (_____)___________________________ Social Security # ____________________

I authorize the following organization to release information as stated below from the patient health information record:

INFORMATION TO BE RELEASED ***FROM:***	INFORMATION TO BE RELEASED ***TO:***
☐ Virginia Mason Medical Center OR	☐ Virginia Mason Medical Center OR
☐ ______________________ Organization/Person Name	☐ ______________________ Organization/Person Name
______________________ Street Address	______________________ Street Address
______________________ City, State, Zip	______________________ City, State, Zip
______________________ Telephone/Fax Number	______________________ Telephone/Fax Number

TYPE OF RECORDS REQUESTED **(Charges for copies of records may be associated with your request)**	
☐ Health care information related to the following treatment or condition:______________________	Sensitive Records may require specific patient authorization. <u>Please initial the appropriate records requested:</u>
______________________	______ Drug and/or Alcohol Abuse
☐ Laboratory/Diagnostic Tests______________	______ Mental Health (may include Pain Management or Psychiatry records)
☐ X-Ray Films______________	
☐ Other______________	______ Sexually Transmitted Diseases (includes AIDS/HIV)

Date range of information needed: Period beginning: ______________ (date) and ending:______________ date)

Purpose or Need for this Information: ☐ Continuing care ☐ Copies for own use ☐ Other ______________

Patient Rights:

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when the recipient has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. To revoke an authorization, I can write a letter to the person or entity holding the authorization, providing details of the date and content of the original authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I do not have to sign this authorization in order to get health care benefit (treatment, payment, enrollment, or eligibility for benefits) except when: (1) my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party, or (3) an authorization is required for health plan eligibility or enrollment or a risk rating determination. Failure to sign an authorization may result in inability to obtain certain benefits in these cases.

I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize to release of patient health information to the above named person or organization.

______________ ______________________________ ______________________
Date: (mo/day/yr) Signature of Patient or Authorized Personal Representative (A minor patient's signature may be required) Authority to sign, if not the patient

This authorization is not valid to release future health care to an employer or financial institution more than 90 days from the date signed (except for payment purposes).

REASONABLE CHARGES

Virginia Mason may charge a reasonable cost-based fee for making copies of records and mailing them. Please review the current fee schedule on the Patient Request for Copies of Their Health Information form prior to ordering any copies of records.

INFORMATION PROTECTED BY STATE / FEDERAL LAW

Release of Mental Health [RCW 71.05], Alcohol and Drug Abuse [RCW 70.96A], Sexually Transmitted Diseases (Including HIV/AIDS) [RCW 70.24], Psychotherapy Notes [45 CFR 164.508(b)(3)(ii)], and certain Minor Treatment Records may require specific patient authorization.

INFORMATION FROM A DRUG OR ALCOHOL ABUSE TREATMENT PROGRAM*

Federal regulations (42 C.F.R. part 2), where applicable, may prohibit any further disclosure of this information except with specific written consent of the person to whom the information pertains or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by federal and state law. A general authorization for the release of information is not sufficient for this purpose. This consent is subject to revocation at any time except to the extent that the program, which is to make the disclosure, has already taken action in reliance on it. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provision of the law shall be fined not more than $500 in the case of a first offense and not more than $5,000 in the case of each subsequent offense. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee3.)

MENTAL ILLNESS INFORMATION **

Where applicable, state law may prohibit any further disclosure of mental illness information without specific written consent of the person, to whom the information pertains, or the parent or legal guardian or a minor child to whom it pertains, unless otherwise permitted by State Law. A general authorization to release information is NOT sufficient for this purpose. (See RCW 71.05.390 through RCW 71.05.410.)

SEXUALLY TRANSMITTED DISEASE INFORMATION (includes HIV / AIDS) ***

State law prohibits any further disclosure of sexually transmitted disease information without specific written consent of the person, to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by State Law. A general authorization is NOT sufficient for this purpose. Any violation of the law is a gross misdemeanor, and the law creates civil remedies for any violation which includes a $1,000 fine for a negligent violation, a $2,000 fine for an intentional or reckless violation or actual damages, whichever is greater, and attorney fees. [RCW 70.24 and WAC 248-100.]

CONSENT OF MINOR ****

Where a minor has the right to consent to medical treatment, he or she also has the right to control information related to that treatment. A competent minor patient's signature may be required to release information related to care of: 1) birth control for minors deemed mature [Smith v. Seibly, 72 2n.2d 16]; 2) treatment for HIV/AIDS sexually transmitted diseases for patients age 14 and above; [RCW 70.05.070, RCW 70.24.110]; 3) to receive HIV/AIDS or STD test results for patients age 15 and above [RCW 70.24.105]; 4) outpatient treatment for alcoholism and drug abuse for patients age 13 and above; [RCW 70.96A.095]; and 5) mental health conditions for patients age 13 and above [RCW 71.34.030(1)]

AUTHORIZED PERSONAL REPRESENTATIVE FOR PATIENTS NOT COMPETENT

A personal representative is an individual that may act on behalf of a patient when a patient is not competent and cannot make his or her own health care treatment decisions. The personal representative may need legal documentation to demonstrate their authority to sign for the patient.

A member of one of the following classes of persons may sign for an adult patient who is not competent to consent, stated in the following order of priority: (a) The appointed guardian of the patient, if any; (b) The individual, if any, to whom the patient has given a durable power of attorney that includes the authority to make health care decisions; (c) The patient's spouse; (d) Children of the patient who are at least eighteen years of age; (e) Parents of the patient, if unanimous; and (f) Adult brothers and sisters of the patient, if unanimous. If a person is not available in a given class to provide authority regarding health care decisions, then a person (or group of persons acting as one) must be found in the next successive class. [RCW 7.70.065(1)].

AUTHORIZED PERSONAL REPRESENTATIVE FOR MINORS

A member of one of the following classes of persons may sign for a minor patient in the following order of priority: (a) the appointed guardian; (b) a person appointed by the court to consent to medical care for a child in out of home placement pursuant to RCW 13.32A or RCW 13.34; (c) parents; (d) an individual to whom a parent has given a signed authorization to make health care decisions for the child; and (e) an adult representing him or herself as responsible for the health care of the minor (a health care provider may, at its discretion, require documentation of this person's claimed status). [RCW 7.70.065(2)].

Note: Under state law each parent has full and equal access to the health care records of their child absent a court order to the contrary. Neither parent may veto the access requested by the other parent. [RCW 26.09.225].