Authorization to Disclose (Release) Health Care Information

1 PATIENT INFORMATION: Birth Date_____ Person Number _____
PRINT Patient Name _____ Other Names _____
Address_____
City, State, Zip _____
Daytime Telephone Number _____

2 INFORMATION TO BE RELEASED FROM (SELECT ONLY ONE):
☐ Puyallup Tribal Health Authority 2209 E 32nd St, Tacoma, WA 98404 (253)593-0232
☐ Organization or provider _____
Address_____
City, State, Zip _____
Phone_____ Fax _____

3 INFORMATION TO BE RELEASED TO: ☐ Check if the same as 1 above
☐ Puyallup Tribal Health Authority 2209 E 32nd St, Tacoma, WA 98404 (253)593-0232
☐ Organization, provider, or person _____
Address_____
City, State, Zip _____
Phone_____ Fax _____

4 PURPOSE OF RELEASE:
☐ Continuing Care ☐ Legal ☐ Insurance ☐ Personal Use ☐ Other (Specify) _____

5 WHAT KIND OF INFORMATION DO YOU WANT RELEASED:
(If neither box is checked, copies of records will be released)

COPIES OF RECORDS ☐Y☐ N **ORAL COMMUNICATION ☐Y☐N** **PATIENT PORTAL ☐Y☐N**

Medical ☐Y☐N **Dental ☐Y☐N** **Mental Health ☐Y☐N** **Treatment Center ☐Y☐N** **Pharmacy ☐Y☐N**

(Two years provided as default; specify dates below if additional or specific dates needed)
☐ Records from date (YOU MUST INDICATE DATES):_____/_____/_____ to date:_____/_____/_____
☐ Immunization Records
☐ Specific Information (please specify): _____

6 PATIENT AUTHORIZATION: I understand that:
- ✓ Information released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness; and for patients age 13-17, information regarding reproductive care. I give my specific authorization for this information to be released.
- ✓ I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 2209 E 32nd St, Tacoma, WA 98404. Revocation will not apply to information that has already been disclosed in response to this authorization.
- ✓ Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.
- ✓ Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- ✓ Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire 90 days from the date signed

7 SIGNATURE:_____ DATE:_____/_____/_____
(Patient, Guardian*, or Authorized Representative*).
[*Documentation may be required to prove authority to sign on behalf of the patient.]

8 MINOR SIGNATURE:_____ DATE:_____/_____/_____
(Signature of minor ages 13-17 is required for certain information.)

9 DELIVERY PREFERENCE: ☐ Paper ☐ CD

Records Contact Information
Phone: (253)593-0232 Ext. 582
Fax: (253)593-3311
Fax: (253)593-3492

BELOW TO BE FILLED OUT BY PTHA

Patient Name: _____

Patient DOB: _____

Date Received: _____

Person Number: _____

INFORMATION RELEASED:

Dates: From/To

- ☐ Assessment(s) _____
- ☐ Consultation _____
- ☐ Discharge Summary _____
- ☐ EKG Report(s) _____
- ☐ Immunizations _____
- ☐ Intake(s) _____
- ☐ Laboratory Report(s) _____
- ☐ Medication List _____
- ☐ Radiology Film(s) _____
- ☐ Radiology Report(s) _____
- ☐ Treatment Plan(s) _____
- ☐ Visit Note(s) _____

_____

- ☐ Other _____

Copied By: _____ Date Sent: _____ Sent By: _____

☐ Mailed ☐ Faxed ☐ Picked up ☐ ID Verified By_____