



# Authorization to Disclose (Release) Health Care Information

**1 PATIENT INFORMATION:** Birth Date \_\_\_\_\_ Other Name(s): \_\_\_\_\_  
PRINT Patient LAST Name: \_\_\_\_\_ Patient FIRST Name: \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Daytime Telephone Number \_\_\_\_\_

**2 INFORMATION TO BE RELEASED FROM (SELECT ONLY ONE):** **TO (SELECT ONLY ONE):**  
 Puyallup Tribal Health Authority 2209 E 32<sup>nd</sup> St, Tacoma, WA 98404 Phone: (253) 593-0232 Fax: (253) 593-3311  
 Organization or provider (details below)  Puyallup Tribal Health Authority 2209 E 32<sup>nd</sup> St, Tacoma, WA 98404 Phone: (253) 593-0232 Fax: (253) 593-3311  
 Self  Organization or someone else (details below)  
Organization, provider, or person \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

**3 PURPOSE OF RELEASE:**  Continuing Care  Legal  Insurance  Other: \_\_\_\_\_

**4 WHAT KIND OF INFORMATION DO YOU WANT RELEASED:**  
Medical  Y  N Dental  Y  N Mental Health  Y  N Substance Use Treatment\*  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  Medication List  
 Specific Information (please specify): \_\_\_\_\_

\* **Substance Use Treatment Addendum:** If you are requesting that the Puyallup Tribal Treatment Center disclose or receive substance use disorder (SUD) information about you, please note that such information may include, but is not limited to, the following types of SUD information: intake assessments and evaluations; presence in treatment; treatment plan; progress notes; mental health history and assessment; medication information; diagnostic tests and results; attendance records; aftercare recommendations; and/or a discharge summary. 42 CFR part 2 prohibits unauthorized disclosure of these records.

**5 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 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 32<sup>nd</sup> 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, for purposes unrelated to treatment, payment, or health care operations.  
 Unless otherwise indicated, this is a one-time release of information. For extended authorization, enter an expiration/end date \_\_\_\_ / \_\_\_\_ / \_\_\_\_.

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

**7 MINOR SIGNATURE:** \_\_\_\_\_ DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Signature of minor ages 13-17 is required.)

**8 DELIVERY PREFERENCE:**  Mail  Paper/Pick Up  CD/USB drive

# 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 \_\_\_\_\_