Authorization to Release Patient Health Information

Please provide complete and accurate information when submitting this form.

Patient Name_____ VMMC
Last First Middle Initial Medical Record #_____

Former Name (if any):_____ Date of Birth _____
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:***

Virginia Mason Medical Center
Department of Pathology
1100 Ninth Avenue
Sixth Floor
Seattle, Washington 98101

Phone (206) 223-6861
FAX (206) 341-0525

INFORMATION TO BE RELEASE ***TO:***

_____
_____
_____

Phone: _____
FAX: _____

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:_____
_____

❑ Laboratory/Diagnostic Tests_____

❑ __ pathology tissue slides

❑ __paraffin blocks and pathology report

Sensitive Records require specific patient authorization.
Please initial the appropriate records requested:

_____ Drug and/or Alcohol Abuse

_____ Mental Health**
(may include Pain Management or Psychiatry records)

_____ Sexually Transmitted Diseases (includes AIDS/HIV)***

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

☐ Research Study

This authorization covers the time period beginning: _____ (date) and ending:_____ (date)

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 more than 90 days from the date signed (except to a payer or for research).