AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION (1 OF 2)

Virginia Mason Medical Center, 1100 9th Ave, Seattle WA 98101, Mailstop A-HIS-ROI FAX 206-223-8885

See back page for instructions to fill out this form. Failure to follow instructions can result in processing delay.

1. PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Phone Number _____ Medical Record # (if known) _____

2. INFORMATION TO BE RELEASED FROM (SELECT ONLY ONE)

☐ Virginia Mason Medical Center

☐ Virginia Mason Provider(s) **(please specify)** _____

☐ Organization/Person _____

Address _____ City, State, Zip _____

Phone _____ Fax _____

3. INFORMATION TO BE RELEASED TO (SELECT ONLY ONE)

☐ Virginia Mason Provider(s) **(please specify)** _____

☐ Organization/Person _____

Address _____ City, State, Zip _____

Phone _____ Fax _____

4. PURPOSE OF RELEASE

☐ Continuing care

☐ Copies for own use

☐ Insurance

☐ Legal

☐ Other (specify below)

_____

5. INFORMATION TO BE RELEASED

Medical records: date from: _____ to: _____

☐ Discharge summaries

☐ Operative reports

☐ Emergency department records

☐ Clinic notes

☐ Lab/pathology reports

☐ Immunizations

☐ Radiology reports

☐ Other (please specify) _____

_____

_____

6. FORMAT OF MEDICAL RECORDS

NOTE: Virginia Mason radiology images and billing records are processed by the respective departments

☐ Paper

☐ CD

☐ Radiology images (on CD) (fax to 206-625-7295)

☐ Billing records (fax to 206-223-6726)

MY RIGHTS / MY AUTHORIZATION

I understand that authorizing the disclosure of this patient health information is voluntary. I understand that I do not need to sign this form in order to assure treatment or payment. I understand that unless expressly limited by me in writing, I am **specifically authorizing** the release of any sensitive medical information that may appear in my medical record including records for mental health treatment including pain management; sexually transmitted diseases; AIDS/HIV treatment; and program records for VM's closed alcohol/drug treatment program (closed 5/93).

I can cancel this authorization at any time by writing to the Health Information Services Department, as also described in Virginia Mason's Notice of Privacy Practices. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled. Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws. This authorization will expire 1 year from the date signed below unless another date or event is entered here _____

Note: If the disclosure is to an employer or financial institution for purposes other than payment, this authorization will expire 1 year from the date signed by you.

7. SIGNATURE

Signature of Patient or Legally Responsible Party _____ Date _____

(If not signed by patient, see information on back page.)

Relationship to patient, if not signed by patient _____

MINOR PATIENT (age 13-17) _____ Date _____

CLINICAL STAFF Has this request been processed? ☐ YES. Send authorization to be scanned to patient's record to mailstop: A-HIS-SCAN ☐ NO. Forward request to be processed by Release of Information at mailstop: A-HIS-ROI

PATIENT NAME & ID #

VIRGINIA MASON MEDICAL CENTER – Seattle WA

Authorization to Release Patient Health Information

ADMROI

DISTRIBUTION: WHITE: Medical Record YELLOW: Patient VMMC Form 905098 (11-15)

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION (2 OF 2)

Instructions – **Please print legibly.** Failure to follow instructions can result in a delay in processing your request.

1. PATIENT INFORMATION. Print patient's name, date of birth, phone number and medical record number (if known).
2. INFORMATION TO BE RELEASED FROM. Select **Virginia Mason Medical Center OR** select **Virginia Mason Provider(s)** and write the name(s) of specific provider(s). If this form is used to request records outside of Virginia Mason, select **Organization/ Person** and write the address, phone and fax information.
3. INFORMATION TO BE RELEASED TO. Select **Organization/Person** and provide the address of the organization or person that is to receive copies of the information. Select **Virginia Mason Provider(s)** if the form is used to send records to a Virginia Mason Provider and indicate the specific provider that is to receive copies of the information.
4. PURPOSE OF RELEASE. Select the reason records are being requested.
5. INFORMATION TO BE RELEASED. Specify what information is to be released.
6. FORMAT OF RECORDS. Select paper or CD. If none is selected, the default format is paper. If CD is selected, the password will be provided on a separate letter.
7. SIGNATURE. Sign and indicate date signed.

   If not signed by patient, documentation may be required to prove authority to sign on behalf the patient. Please read information below:

   AUTHORIZED PERSONAL REPRESENTATIVE FOR ADULT PATIENTS NOT COMPETENT

   A personal representative is an individual who may act on behalf of a patient when the patient lacks decision-making capacity to make health care treatment decisions. The personal representative may need legal documentation to demonstrate authority to sign for the patient. A member of one of the following classes of persons may sign for an adult patient who lacks capacity to consent, 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 or state registered domestic partner; (d) children of the patient who are at least eighteen years of age; (e) parents of the patient; and (f) adult brothers and sisters of the patient. 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 or authorized legal custodian (Title 26); (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]

   A minor patient's signature is required to release the following information:

   1) Information related to reproductive care such as birth control and pregnancy-related services;
   2) Sexually transmitted diseases, including HIV/AIDS (age 14 and older);
   3) Substance abuse and mental health treatments (age 13 and older).

Send completed **Authorization to Release Patient Health Information** form by mail or by fax:

ADDRESS: Virginia Mason Medical Center
1100 Ninth Avenue, Mailstop A-HIS-ROI
Seattle, WA 98101

REQUESTS FOR:	FAX	PHONE
Medical Records	206-223-8885	206-223-6975
Radiology Images (on CD)	206-625-7295	206-583-6595
Billing Records	206-223-6726	206-223-6601

PATIENT NAME & ID #

VIRGINIA MASON MEDICAL CENTER – Seattle WA

Authorization to Release Patient Health Information

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