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 Alcoholics Anonymous

Address _____ City, State, Zip _____

Phone _____ Fax _____

4. PURPOSE OF RELEASE

☐ Continuing care

☐ Copies for own use

☐ Insurance

☐ Legal

☒ Other (specify below)

to receive information about AA services

5. INFORMATION TO BE RELEASED

Date from: _____ to: _____

☐ Discharge summaries

☐ Operative reports

☐ Emergency department records

☐ Clinic notes

☐ Lab/pathology reports

☐ Immunizations

☐ Radiology reports

☐ Radiology images (on CD)

☐ Billing records

☒ Other (specify below)

name, location in hospital, sex

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

6. FORMAT OF RECORDS (SELECT ONLY ONE)

☐ Paper ☐ CD **(requires email address** so we can send password for CD): email, verbally by phone call

MY RIGHTS

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 this authorization may include release of the following sensitive medical information unless I have initialed below to exclude such information:

____ mental health treatment (including pain management)

____ alcohol and/or drug abuse treatment (VM's program closed 5/93).

____ sexually transmitted diseases

____ AIDS / HIV treatment

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 _____

ROI DEPT Request has been forwarded to the ☐ Radiology Dept. ☐ Billing Dept. ☐ Other: _____

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

DISTRIBUTION: WHITE: Medical Record YELLOW: Patient VMMC Form 905098 (12-14)

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, **print** your email address so the password to the encrypted CD can be provided via email. If both are selected, we will send CD only.
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

FAX NUMBER: 206-223-8885 (for requesting Medical Records)
206-625-7295 (for requesting Radiology Images on CD)

For questions, please contact Release of Information at 206-223-6975.

PATIENT NAME & ID #

VIRGINIA MASON MEDICAL CENTER – Seattle WA

Authorization to Release Patient Health Information