Authorization for Release of Information

Patient Information

Patient Name: _____

Patient DOB (mm/dd/yyyy): _____ **Patient SSN:** _____

Information to be released from:

_____
_____
_____
_____
_____

Information to be sent to:

Pierce County Risk Management
955 Tacoma Ave S, Suite 303
Tacoma, WA 98402
(253) 798-6283

Information to be released

All medical records (chart notes, admin records, tests, reports, correspondence, etc.)
All medical bills and insurance billings.
Specific information (Please specify: i.e. x-rays, etc.) _____
_____

Patient Authorization

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*** EXCLUDE the following information from the records released (please initial):**

_____ Drug/Alcohol abuse/treatment & diagnosis
_____ Sexually Transmitted Disease
_____ Mental Illness or Psychiatric diagnosis/treatment
_____ HIV/AIDS diagnosis/treatment/testing

Patient Rights

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____

Such release of the foregoing shall be authorized upon presentation of this authorization or any duplicate or photostatic copy of thereof.

This authorization will expire 90 days from the date signed.