## **Patient Information**

Name (Please print full name):	Date of Birth:	
Address:	Phone #:	
MRN:	Email:	
Release format: D Paper Copy D Elec	tronic Delivery 🛛 Electronic Hard Copy (CD-R	OM) 🔲 Verbal/Oral discussions
I authorize the mutual exchange of inform	ation between the listed entities. Initials	
Request information from listed provider: $\Box$	MultiCare Health System 🛛 PACE 🔲 No	avos 🛛 Greater Lakes
Other: Name/Organization:		
Phone: En	nail:	Fax:
Address:		
	on:	
Phone: Email:	Fa	X:
Address:		
Purpose of Release: Health Care	Personal Legal/Investigative/Judicial Action	on 🗖 Billing 🗖 Insurance
What information should be released:		
Select type(s) of information that n Routine Medical Records SetsOR	nay be released. Specific Medical Records Documents Only	MH = Mental Health SUD = Substance Use Disorder
<ul> <li>Clinic Records (Includes: Office Visit, Laboratory, Radiology, Medication Record, Immunization Record</li> <li>Hospital Records (Includes: History and Physical, Discharge Summary, Operative Report, Consultation Emergency, Laboratory, Radiology)</li> <li>Access Records</li> <li>Billing Records</li> <li>Discharge Summary/Note</li> <li>History and Physical</li> <li>Operative Report</li> <li>Radiology Report</li> <li>Radiology Images and Films</li> <li>Laboratory Report</li> <li>Other (please specify):</li> <li>Specific Dates of Service or Condition-</li> </ul>	<ul> <li>Medication/Psychiatric Evaluation</li> <li>MH Prog Notes/Group Notes</li> <li>Psychological Evaluation</li> <li>MH Treatment Summaries/Plans</li> <li>MH Letter/Summary of Client Treatment/Attendance</li> <li>MH Crisis/DCR Contact/ITA Notes</li> <li>MH Crisis Plans</li> </ul>	<ul> <li>SUD Scheduling Appointment Verification Information</li> <li>Completion of Dept of Licensing On-Line Form</li> </ul>
Special information: I authorize the inclusi	cal history and care: on of the following information with this release (	(initial all that apply)
	ng HIV/AIDS Psychiatric, mental or k	
Substance Use Disorder (SUD) informa		
*** NOTE: If this section is not completed, records of t Patient Identification - Write in or attach patient la		SIGNATURE REQUIRED ON PAGE 2 ELEASE HEALTH CARE
Name:		
MRN #:	INFORMATION OR PHI	
CSN #:	MultiCare <b>A</b>	
Age / Sex & Gender:	Page 1 of 2	87-8455-5e A (Bay 11/22)
5	· · · · · · · · · · · · · · · · · · ·	07-0400-04 (Nev. 11/20)

# AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (PROTECTED HEALTH INFORMATION OR PHI) (continued)

## Your rights and other notices:

- 1. Once MultiCare releases your health information, the recipient may re-disclose that information and privacy laws may no longer protect it. Some information, such as substance use disorders or mental health may still be protected.
- 2. I can withdraw this authorization at any time (please refer to Revocation section below). If I withdraw my authorization it will not change actions that were already taken according to the authorization.
- 3. MultiCare does not require you to complete this authorization to receive healthcare or healthcare benefits. However, you must sign this authorization form when the purpose of healthcare services or research participation is to create or receive health care information.
- 4. I understand this request for records may result in charges. I understand I will be contacted with an estimate of those charges before the records are produced. More information on charges can be found at www.multicare.org/medical-records/.

## **Expiration:**

This authorization is valid for 365 days from the date of signature or until the date or event specified here: \_\_\_\_\_

# Signature: Patient/Representative: Date/Time: Legal Authority: Minor Signature: (Signature of the individual and date) If co-signature is required for minors If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act

for the individual must also be provided.

Printed Name & Date: \_

### \_Relationship: \_

## REVOCATION

You may revoke this authorization in writing. You may call one of the departments listed or obtain the hospital address under Health Information Management (Medical Records) Locations on https://www.multicare.org/medical records. The revocation will be effective upon receipt, but will not apply to information that has already been released or to services already provided according to this authorization.

Inland Northwest Deaconess Hospital: 509-603-7421

Inland Northwest Rockwood Clinic: 509-342-3955

Inland Northwest Valley Hospital: 509-603-5431

Puget Sound MultiCare Hospitals: 253-403-2433

Greater Lakes Mental Health: 253-620-5150 Navos: 206-257-6608 MultiCare Behavioral Health: 253-697-8530

**CONSENT FOR MINOR** 

A signature of a minor patient is required to release information concerning care for: (1) birth control and pregnancyrelated care, (2) sexually transmitted disease information (including HIV/AIDS) if the minor is 14 or older, (3) substance use disorder diagnosis, treatment, or referral information (for capable minors under 13, both minor and guardian must consent), and (4) outpatient mental health information if the minor is 13 or older.

## MULTICARE USE ONLY

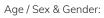
- □ Was the request completed and medical records released to an external provider? []YES []NO
- □ Was this request sent to an external provider or hospital to obtain medical records? []YES []NO
- Is this an authorization for verbal communications or ongoing discussion that only needs to be filed for reference?
   []YES []NO

Patient Identification - Write in or attach patient label

Name:

MRN #:

CSN #:



# AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (PROTECTED HEALTH INFORMATION OR PHI)

MultiCare 🞜



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