Unity Care NW

1616 Cornwall Avenue
Bellingham WA 98225
Phone: 360.676.6177
Toll Free: 877.235.6850
Fax: 360.671.3574

AUTHORIZATION TO OBTAIN OR DISCLOSE HEALTH CARE INFORMATION

Patient Name: _____ **Date of Birth:** _____

Previous Name: _____ **SSN:** _____

Release records from:	*Release records to:*
Facility/Name: _____	Facility/Name: _____
Address: _____	Address: _____
_____	Phone: _____
Phone or Fax #: _____	Fax #: _____

You may use or disclose the following health care information (check all that apply):

☐ All health care information in my record, including testing and diagnosis for HIV, sexually transmitted diseases, psychiatric disorders/mental health, drug and/or alcohol use. Send two years worth of records up to and including the most recent dates of service.

☐ Specific health care information in my record relating to the following treatment or dates:

_____

_____

Format of requested records: ☐ PAPER ☐ ELECTRONIC (Compact Disk)

Do *NOT* send records regarding (check any that apply):

☐ HIV/AIDS
☐ Psychiatric disorders/mental health
☐ Other _____
☐ Sexually transmitted diseases
☐ Drug and/or alcohol use

Reason (s) for this authorization (check all that apply):

☐ At Patient Request
☐ Patient Personal Use (a fee may be required)
☐ Transfer of Care / Continuity of Care
☐ Mutual Exchange, no paper records needed at this time
☐ Verbal Exchange of Information
☐ Other (specify) _____ Legal? Insurance?

This authorization ends (Please check **ONE** of the following options):

☐ in 90 days from the date signed
☐ one year from the date signed
☐ other: _____
(No longer than one year from date signed)

Patient Notices

I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal and state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information

I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations or if the services related to the information to be disclosed are performed solely for the purpose of providing that information to someone else.

I may revoke this authorization at any time by notifying the Health Information Management/Medical Records Department of Unity Care NW. However, any such revocation will not apply to any activity undertaken based on this authorization.

_____ _____

Patient or legally authorized individual signature **Date**

_____ _____

Printed name if signed on behalf of the patient **Relationship**

Requesting Provider _____

For Administrative Use Only

Date Sent_____/_____/____ Initials _____
Faxed _____ Mailed _____ Patient Pick Up _____
Scan/File Only _____