Unity Care NW

1616 Cornwall Ave
Bellingham, WA 98225
Phone: (360) 676-6177
Fax: (360) 671-3574

Release of Information Form

Please use this form to tell us who UCNW may release your records to or who may release your records to UCNW.

Patient Legal Name: ________________________________ **Date of Birth:** ____________________

Patient Preferred Name: ____

I authorize: Unity Care NW 1616 Cornwall Ave, Ste #205 Bellingham, WA 98225 Phone: 360-676-6177 Fax: 360-671-3574	☐ To **Send** Records To: -OR- ☐ To **Receive** Records From: Facility/Recipient Name: ______________________________________ Address: ____ ____ Phone:____________________ Fax:________________________

Disclosure Format: ☐ Mail ☐ Fax ☐ Electronic (CD) ☐ Electronic (USB) ☐ Pick Up at Clinic

Purpose of Disclosure: ☐ Transfer of Care ☐ Legal ☐ Continuation of Care ☐ Insurance ☐ Other

UCNW Receiving Records: You may disclose the following healthcare information to Unity Care NW:

☐ Office visit notes for care provided in the most recent 2 years regarding the following Medical condition(s):
____

☐ Other: ____

☐ All of the following for the last 12 months:

- Problem List
- Medication List
- Surgical History
- Family History
- Immunizations
- Lab Results
- Imaging Results
- Any Known Allergies
- Preventative screenings: pap smear/mammogram/colon cancer screening/low dose lung CT/AAA screen

Based on the above, I also authorize the specific release of information regarding*:

☐ Alcohol, Drug, or Substance Abuse ☐ Sexually Transmitted Diseases ☐ Reproductive Health
☐ Mental Health / Psychotherapy ☐ HIV/AIDS ☐ Genetic Testing

*A minor patient's signature is required to disclose information related to reproductive care (at any age), sexually transmitted diseases (14 or older), HIV/AIDS (14 or older), alcohol, drug, or substance abuse (13 or older), and mental health (13 or older).

UCNW Sending Records: Unity Care NW may disclose the following healthcare information:

☐ All Healthcare Information ☐ Dates of Service: ___________ to ___________
☐ Diagnostic Results (Laboratory, Radiology, Pathology, etc) ☐ Billing / Payment Records
☐ Specific healthcare information relating to the following treatment or condition:
____

Based on the above, I also authorize the specific release of information regarding*:

☐ Alcohol, Drug, or Substance Abuse ☐ Sexually Transmitted Diseases ☐ Reproductive Health
☐ Mental Health / Psychotherapy ☐ HIV/AIDS ☐ Genetic Testing

*A minor patient's signature is required to disclose information related to reproductive care (at any age), sexually transmitted diseases (14 or older), HIV/AIDS (14 or older), alcohol, drug, or substance abuse (13 or older), and mental health (13 or older).

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This authorization will expire: ☐ When I revoke my authorization or when I am no longer a patient at Unity Care NW
☐ 90 Days
☐ Other Timeframe: ________________________________

By signing this authorization form, I understand that:

- I do not have to sign this authorization to get healthcare benefits (treatment, payment, enrollment, or eligibility for benefits).
- However, I do have to sign an authorization form to receive research related treatment in connection with research studies and/or to receive healthcare when the purpose is to create healthcare information for a third party.
- I may revoke this authorization in writing at any time by notifying the Health Information Management/Medical Records Department at Unity Care NW by mailing my request to the address at the top of this form or by dropping it off at any UCNW front desk. However, any such revocation will not apply to any activity previously undertaken based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.
- Information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

____

Patient or Legal Guardian Signature **Date**

____

Print Name **Relationship to Patient (if applicable)**

UCNW Administrative Use Only - Requesting Provider: ____