Unity Care NW

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

Disclosure Format: ☐ Mail ☐ Fax ☐ Paper – Patient Pick Up (under 50pgs) ☐ Verbal for Professional Services

Purpose of Disclosure: ☐ Transfer of Care ☐ Legal ☐ Mutual Exchange ☐ Insurance ☐ Other

You may disclose the following healthcare information:

☐ All the following records for the last 12 months:
- Problem/Medication/Allergy List
- Surgical/Family History
- Lab/Imaging Results
- Immunizations
- Preventative screenings: Pap Smear/Mammogram/Colon Cancer Screening/Low Dose Lung CT/AAA Screen

☐ All office visit notes for care provided in the most recent 2 years

☐ Other: _____

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

☐ Alcohol, Drug, or Substance Use ☐ 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 use (13 or older), and mental health (13 or older).

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.
- 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. If the information being disclosed under this authorization includes HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol use 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 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.

_____

Patient or Legally Authorized Representative Signature **Date**

_____

If Signing for Patient - Print Name **If Signing for Patient - Relationship to Patient**