Medical Release

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Sound Health Care CENTER
463 Tremont St W Suite #200
Port Orchard, WA 98366-3743
Phone: (360) 876-2434
Fax: (360) 876-2696

PATIENT INFORMATION

Full Name

Date of Birth (mm/dd/yyyy)

Mailing Address

Phone: □ Home □ Work □ Cell

City State Zip

REASON FOR REQUEST

□ Personal □ Transfer of Care □ Concurrent Care □ Other (please explain)

WHO NEEDS THE RECORDS

SHCC sends out records

I request and authorize SHCC to release information to

Provider or Organization

Mailing Address

City State Zip

Phone Fax

SHCC receives records

I request and authorize the provider/clinic indicated below to release health information to SHCC.

Provider or Organization

Mailing Address

City State Zip

Clinic Phone Clinic Fax

WHAT NEEDS SENT

Information to be disclosed is indicated by checked box

□ All / Entire Record *
□ Colonoscopy
□ Consults
□ Discharge Summary
□ EKG / Cardiology Testing Results
□ ER Record
□ History & Physical
□ Home Care Records
□ Lab Results
□ Mammography
□ Medication List – Current
□ Operative Report
□ Pathology Report
□ Progress Notes / Visit Notes
□ Radiology Results
□ Behavioral Health Information * (e.g. stress, anxiety, depression)
□ Human Immunodeficiency Virus (HIV) *
□ Sexually Transmitted Diseases *
□ Substance Abuse Information *
□ Other Please specify:

* *See special authorization section below*

SPECIAL AUTHORIZATION

If you are authorizing the release of information related to the testing diagnosis and/or treatment for any of the following conditions, please initial next to the section which describes the type of information to be released.

	Patient Initials	Guardian Initials		Patient Initials	Guardian Initials
Substance Abuse			HIV/AIDS		
Mental Health (stress, anxiety, depression)			Sexually Transmitted Diseases		

MINORS AGE 13-17: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minors reproductive care including, but not limited to: contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent and that authorizing the disclosure of the health information is voluntary. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be re-disclosed by the recipient. I do not need to sign this form in order to assure treatment or payment. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. I understand I have the right to revoke or cancel this authorization, in writing, at any time. Authorization will expire in 90 days.

Patient Signature

Date

Parent or Legal Guardian Signature

Date

Parent or Legal Guardian Printed Full Name

Relationship (parent, legal guardian, personal representative)

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Sound Health Care CENTER

PATIENT RIGHTS AND IMPORTANT INFORMATION

Please read all information and instructions below completing and signing the authorization form.

CANCELLATION NOTICE

According to the Uniform Health Information Act for the State of Washington, records shall be released within fifteen days after receipt of a signed, dated release form. Since records are usually handled within 2 – 3 days after receipt, Sound Health Care Center will not be held responsible for any release of medical information accomplished before receipt of a written notice of cancellation. Revocation takes place from the date of receipt of written request.

Instructions for Canceling a Request:

1. You must provide a written request to the SHCC asking for revocation/cancellation of the original record release.
2. We need to have your complete name, date-of-birth, telephone number (home/work) and the name of the person/agency that you authorized to receive the medical information. Mail or bring this information to: Sound Health Care Center 463 Tremont St. W, St. 200, Port Orchard, WA 98366
3. After receipt of the notice by our office, telephone confirmation will acknowledge your withdrawal of authorization.
4. If the release has been accomplished, you will be notified by a representative of our staff. The release will be revoked for any further disclosure.
5. If you have any questions concerning the cancellation process, call SHCC at 360-876-2434.

MENTAL HEALTH INFORMATION

State law (RCW 71.05.39) prohibits any further disclosure (re-disclosure) of mental health information without specific written consent of the person to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by state law. A general authorization to release information is NOT sufficient for this purpose.

DRUG AND ALCOHOL ABUSE INFORMATION

Federal regulations (42 CFR Part 2) prohibit any further disclosure of this information except with specific written consent of the person to whom the information pertains or the parent or legal guardian of the minor child to whom it pertains (if the minor patient is 13 or older the minor patient's signature is required), unless otherwise permitted by federal law. A general authorization for the release of information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

SEXUALLY TRANSMITTED DISEASE INFORMATION

State law prohibits any further disclosure of this information without specific written consent of the person to whom the information pertains, or the parent or legal guardian of the minor child to whom it pertains (if the minor patient is 14 or older the minor patient's signature is required), unless otherwise permitted by state law. A general authorization to release information is NOT sufficient for this purpose. (See RCW 70.24 and WAC 246-100.)

CONSENT OF A MINOR (RCW 70.96A.230, RCW 70.96A.235, RCW 70.96A.095)

A minor patient's signature is required on the patient signature line to release the following information only:

1. Conditions relating to reproductive care including, but not limited to , birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS (age 14 and older); and
2. Substance abuse diagnosis or treatment and mental health conditions (age 13 and older).

A parent or legal guardian signature is required for the release of all other health care information for minors.

PROHIBITION ON RE-DISCLOSURE OF HEALTH INFORMATION

Federal and state prohibit re-disclosure of information concerning drugs and alcohol abuse treatment, sexually transmitted disease information or mental health information without the specific written consent of the person to whom the information pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.