I HEREBY REQUEST AND GIVE MY PERMISSION TO RELEASE FOLLOWING INFORMATION:

INFORMATION TO BE RELEASED BY:
HealthPoint
955 Powell Avenue SW
Renton, WA 98057
Fax: (425) 203-0407
Phone: (425) 277-1311

REASON FOR REQUEST:  ☐ Legal  ☐ Insurance  ☐ Personal Use  ☐ Continuing Health Care  ☐ Transfer of Care  ☐ Other:

INFORMATION TO BE RELEASED - Choose (1)
☐ All health information
☐ Medical
☐ Dental
☐ Health Information from
☐ TO
☐ Specific Health Information About:

☐ I wish to receive my records electronically. My email address is:

Date __________ Signature of patient or patient’s representative __________ Relationship if not Patient __________

RELEASE REQUIRING SPECIFIC CONSENT:
My signature below gives you permission to release ANY and ALL confidential information relating to testing, diagnosis or treatment. I understand if I initial any of the confidential information below, it WILL NOT be released.  
☐ HIV/AIDS (>14 yrs)  ☐ Mental Health (>13 yrs)
☐ Sexually Transmitted Diseases (>14 yrs)  ☐ Alcohol/Drug Abuse (>13 yrs)
☐ Reproductive Care (minors only - no minimum age)

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

Date __________ Signature of patient or patient’s representative __________ Relationship if not Patient __________
☐ Check if patient is a minor

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits) except if I receive health care when the sole purpose of the health care is to create health information for a third party.

I understand that: a) I must revoke my permission in writing and may do so by completing and signing the Revocation of Permission form, available at the medical records office; b) If I revoke my permission, it will not affect any actions already taken by HealthPoint based on this permission; and c) I may not be able to revoke this permission if the purpose of it was to obtain insurance.

Once HealthPoint has disclosed health information, the recipient may re-disclose it in some situations. Privacy Laws may no longer protect the information.

My permission expires on _________________ (date or event). Authorization will expire in ninety (90) days if no date is entered.

HEALTHPOINT STAFF ONLY
I have verified:  ☐ form complete  ☐ identification (if appropriate)  ☐ Relationship if not patient
Processed by:  Name: ___________________________ Position: ___________________________ Date: __________

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