HealthPoint

PERMISSION TO RELEASE HEALTH CARE INFORMATION

Patient Full Name (include middle initial)	**Patient Date of Birth**
Previous Name if Applicable	**Day Time Phone Number**

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

INFORMATION TO BE RELEASED BY:		**INFORMATION TO BE RELEASED TO:**	
HealthPoint		NAME:	
955 Powell Avenue SW		ORGANIZATION:	
Renton, WA 98057		ADDRESS:	
Fax:	**(425) 203-0407**	CITY, STATE ZIP:	
Phone:	**(425) 277-1311**	Phone & Fax:	

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.**

_____ Mental Health (>13 yrs)

_____ HIV/AIDS (>14 yrs)

_____ Alcohol/Drug Abuse (>13 yrs)

_____ Sexually Transmitted Diseases (>14 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 pregancy 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: _____