HealthPoint

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

PLEASE READ CAREFULLY. FAILURE TO COMPLETE THIS FORM MAY RESULT IN DELAY OR REJECTION.

Patient Full Name: _____ Patient Date of Birth:_____

Previous Name if Applicable:_____ Phone Number:_____

INFORMATION TO BE RELEASED BY:	INFORMATION TO BE RELEASED TO:
HealthPoint 955 Powell Avenue SW Renton, WA 98057 Phone: 425-277-1311 Fax: 425-203-0407 roi@healthpointchc.org	Name:_____ Organization:_____ Address:_____ City, State Zip:_____ Phone/Fax:_____

PURPOSE OF REQUEST: ☐LEGAL ☐INSURANCE ☐PERSONAL USE ☐CONTINUING HEALTH CARE

☐TRANSFER OF CARE ☐OTHER (PLEASE SPECIFY)_____

INFORMATION TO BE RELEASED: ☐ ALL HEALTH INFORMATION ☐ MEDICAL ☐ DENTAL

☐HEALTH INFORMATION FROM DATES:_____TO_____

☐SPECIFIC HEALTH INFORMATION ABOUT: _____

FORMAT (CHECK ONE): ☐PAPER ☐CD ☐EMAIL (PATIENT ONLY):_____

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

My signature below gives you permission to release ANY and ALL confidential information related to testing, diagnosis or treatment of HIV/AIDS, sexually transmitted disease, mental health, or substance use.

MINORS 13 AND OLDER - A minor patient's signature is required in order to release the following information: HIV/AIDS, sexually transmitted disease, mental health, substance use, or reproductive care (no minimum age).

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 have the right to revoke this authorization in writing at any time b) If I revoke my permission, it will not affect any actions already taken by HealthPoint based on this permission; c) I may not be able to revoke this permission if the purpose of it was to obtain insurance. d) information disclosed under this authorization might be redisclosed by the recipient, and may no longer be protected by privacy laws. I understand that per state law HealthPoint has 15 business days to respond to a request starting from the date it is received, and that there may be a cost associated with duplicating health care records.

DATE **SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE** ***RELATIONSHIP IF NOT PATIENT**

DATE **SIGNATURE OF MINOR PATIENT AGED 13-17**

***If signed by someone other than the patient, legal documentation may be requested to show authority to sign on their behalf, such as guardianship or power of attorney.**