

**THE POLYCLINIC  
AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient Name				
	Last	First	Middle	Maiden
Address				
	Street	Apt. #	City	State      Zip
Phone	(      )		Date of Birth	/      /

**I AM REQUESTING THIS INFORMATION BECAUSE:**

- |  |  |  |                                |
|--|--|--|--------------------------------|
| <input type="checkbox"/> Personal Use* | <input type="checkbox"/> Legal Use**               | <input type="checkbox"/> Transferring Care | Reason:                        |
| <input type="checkbox"/> Insurance**   | <input type="checkbox"/> Dissatisfaction with care | <input type="checkbox"/> Continuing Care   | <input type="checkbox"/> Other |

**NOTE:** A charge may be incurred for copies being provided for legal, insurance, personal use and, in some instances, the "other" category

Once Protected Health Information is released by The Polyclinic, it can not be guaranteed that the recipient will not disclose the information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of health information. I understand that I do not have to sign this form to receive health care benefits.

**Please Check One**

Health care information relating to the following treatment(s), condition(s), or dates of treatment(s):

\_\_\_\_\_

Last two years of pertinent health information only (i.e. consults, labs, x-rays, etc.)

Other (please specify): \_\_\_\_\_

\_\_\_\_\_

**Please Check One: (If no box is checked "sensitive" information will not be released.)**

Your facility  **is** /  **is not** authorized to release any health care information relating to such diagnosis, testing, or treatment relating to the: **testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders / mental health, or treatment of drug and/or alcohol abuse.**

**NOTE:** In compliance with Washington state law, minors must sign the request themselves if information requested includes: a) treatment for alcohol and/or drug abuse (13 and older), b) mental health conditions or c) conditions related to the minor's reproductive care and sexual history to include contraception, pregnancy, pregnancy termination, sterilization and STDs (age 14 or older).

**Please complete the appropriate information:**

I request and authorize The Polyclinic **to release** health information to:

**Physician / Clinic Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

I release The Polyclinic and its staff from all legal responsibility or liability that may arise from the release of information. I understand that I may revoke this consent in writing at any time, except when action has already been taken.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Relationship or Status if signed by anyone other than Patient (i.e. Parent, Legal Guardian, Personal Representative, etc.) \_\_\_\_\_ Date \_\_\_\_\_

**THIS AUTHORIZATION IS VALID FOR ONE YEAR OR UNTIL THE FOLLOWING EVENT OCCURS:** \_\_\_\_\_

**Mail Requests & Payments ONLY to:**

THE POLYCLINIC  
ATTN. RELEASE OF INFORMATION  
1145 BROADWAY  
SEATTLE, WA 98122

**Copy Fees:**

**Patient**  
Less than 10 pages or last 2 years are free.  
\$0.42 / page or \$20 (whichever is less) for over 2 yrs.

**Third-Party Vendors (PRE-PAY ONLY)**

\$21 clerical fee, \$0.91 / pg < 30 and \$0.69/pg 30+

**FEE APPROVALS & REQUESTS may be faxed to:** (206) 860-4513  
**FOR TELEPHONE PAYMENTS, please call:** (206) 860-4400, Ext. 3719

