

**THE POLYCLINIC
AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

| | | | | |
|------------------------------|----------|-------|---------------|--------|
| Patient Name | | | | |
| | Last | First | Middle | Maiden |
| Address | | | Apt. # | City |
| | Street | | State | Zip |
| Phone | () | | Date of Birth | / / |
| Polyclinic Physician's Name: | | | SSN | - - |

By signing this authorization, I authorize the use or disclosure of my health information maintained by: _____

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

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 check one and complete the appropriate information:

| | |
|---|---|
| <input type="checkbox"/> I request and authorize The Polyclinic to release health information to: Physician / Clinic Name: _____ Address: _____ City, State: _____ Zip Code: _____ | <input type="checkbox"/> I request and authorize your facility to release the above indicated health information to The Polyclinic location shown below: Physician Name: _____ Clinic 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.

FEE APPROVALS & REQUESTS may be faxed to: (206) 860-4513
FOR TELEPHONE PAYMENTS, please call: (206) 860-4400, Ext. 3719
EMAIL ADDRESS: ROI@POLYCLINIC.COM

Third-Party Vendors (PRE-PAY ONLY)
 \$21 clerical fee, \$0.91 / pg < 30 and \$0.69/pg 30+

