THE POLYCLINIC
Part of Optum®

The Polyclinic File Room for
Diagnostic Imaging Center and Breast Imaging
Center 1145 Broadway, Seattle WA 98122

Please fax this completed form to 1-206-860-4539.
If you have questions about your request, please call 1-206-860-5496, option 3.

Patient authorization to disclose, release and/or get protected health information

Patient name:________________________________DOB:_________MRN:______________________

Reason or need for disclosure, please select one:

☐ Lawyer ☐ Insurance ☐ Provider ☐ Personal ☐ Other (specify):______

Information to be sent from:
Name of facility/provider: ____
Address:____________________________________City:___________State:______ZIP_____________

Information to be sent to:
Name of facility/provider: ____
Address:____________________________________City:___________State:______ZIP_____________

Please select the records to be shared:
☐ MRI (magnetic resonance imaging) ☐CT (CAT scan) ☐NM (nuclear medicine)
☐US (ultrasound) ☐ X-ray ☐ Mammography ☐ Breast ultrasound ☐ Breast MRI ☐ pathology reports
☐ Include mammography/breast ultrasound reports ☐ Include imaging reports

PATIENT AUTHORIZATION

I understand that my medical records may contain information regarding the diagnosis of treatment of HIV/AIDS, sexually transmitted disease, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (PLEASE INITIAL)

____Drug/alcohol abuse/treatment and diagnoses ____Sexually transmitted disease

____HIV/AIDS diagnosis/treatment/testing ____Mental illness or psychiatric diagnosis/treatment

MY RIGHTS

I understand I do not have to sign this authorization in order to obtain health care benefits (treatments, payments or enrollment) and that I may revoke this authorization in writing. Patient or Personal Representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

Print patient name:_____________________________Relationship: _____________

Signature:___________________________________ Date: __________________
(Patient, guardian or authorized representative)

Fee disclaimer: Federal and state laws permit Optum to charge a reasonable fee for copying/releasing records. State regulated fees for labor and supplies may apply. You will be notified in advance regarding any fees and payment as required.

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED