Patient Authorization to Disclose, Release and/or Obtain Protected Health Information

1. Patient Information

Name- Last, First, MI		Former Name(s)/Alias:	
Street Address	City	State	Zip
Medical Record Number (if known)	Birthdate	Phone Number	

2. Purpose or need for disclosure - may be released electronically. (Please check all applicable categories)

☐ Attorney ☐ Insurance ☐ Provider ☐ Personal ☐ Other (specify)_____

3. Records to be released from:

☐ Kent Eye Clinic
☐ Contact Lens & Dry Eye Center
☐ Other: _____

4. Records to be disclosed to: (e.g. Insurance Company, Attorney, Physician, Patient)

Name	Telephone	Fax#	
Street Address	City	State	Zip

5. RECORDS to be disclosed:

☐ **Comprehensive overview** of chart (contains discharge summaries, admit note, history & physical, operative note, emergency department note, pathology reports, clinic summaries, radiology/diagnostic reports, EKG, and lab reports) **from date:** _____ **to date:** _____
(If timeframe not specified most recent 2 years of medical records will be provided)

☐ **Images** (specify type – e.g. radiology, endoscopy, will be on CD) _____

☐ **Other** (specify type (required) – e.g. discharge summary, operative reports, lab reports, billing records, or entire legal health record.)

_____

AND/OR:

☐ **I authorize VERBAL COMMUNICATION ONLY about my medical history and care.** (Checking this box means no physical records will be sent unless otherwise indicated by checking additional boxes in sections 5 and 6.)

Patient Authorization: Unless otherwise indicated, I authorize sensitive information about my conditions which may include sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include sensitive information about behavioral or mental health services and treatment for alcohol and drug abuse. ☐ **Do not include this sensitive information.**

7. This authorization is in effect until _____ (date) **OR** when the following event occurs: _____
(State when UW Medicine is no longer authorized to disclose my information based on this authorization. If no date or event is listed above, this authorization is valid for three years from the date on which it is signed.)

Note: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of one year from the date signed by you.

Signature (Patient Or Person Authorized To Give Authorization)	Date
If Signed by Person Other Than Patient, Provide Printed Name, Reason, Relationship to Patient, Description of Their Authority	

By signing this page, I acknowledge that I have read and agree to the terms on both sides of this form.
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Minors: A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care (2) sexually transmitted diseases (if age 14 and older), (3) alcohol and/or drug abuse and mental health conditions (if age 13 and older).