



# Peninsula Community Health Services

Provides accessible, affordable, quality health and wellness services for our communities

## PERMISSION TO RELEASE HEALTH CARE INFORMATION

Patient Full Name (include middle initial)	Patient Date of Birth
Previous Name if Applicable	Day Time Phone Number

I HEREBY REQUEST AND GIVE MY PERMISSION TO RELEASE THE FOLLOWING INFORMATION:

<b>INFORMATION TO BE RELEASED BY:</b> (Must supply contact information)	<b>INFORMATION TO BE RELEASED TO:</b>
NAME: _____	Peninsula Community Health Services
ORGANIZATION: _____	P. O. Box 960
ADDRESS: _____	Bremerton, WA 98337
CITY, STATE ZIP: _____	Fax: (360) 874-5595
Phone & Fax: _____	Phone: (360) 377-3776

REASON FOR REQUEST:  Legal  Insurance  Personal Use  Continuing Care  Other: \_\_\_\_\_

### INFORMATION TO BE RELEASED - Choose (1)

- Information from the most recent 2 years of visits
- Health Information from \_\_\_\_\_ TO \_\_\_\_\_
- Specific health information about: \_\_\_\_\_
- \*  Please mark if you DO NOT wish to receive records on CD

Date	Signature of patient or representative	Relationship if not Patient
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\*Restrictions: Only medical records originated through this healthcare facility will be provided unless otherwise specifically requested. This authorization is valid only for the release of information dated prior to and including the date on this form.

<b>RELEASE REQUIRING SPECIFIC CONSENT:</b>	My signature above gives you permission to release <b>ANY and ALL</b> confidential information relating to testing, diagnosis or treatment. Per 42 CFR part 2 (See * <b>Statement Below</b> ) I understand If I initial any of the following categories of confidential information it <b>WILL NOT BE</b> released.
_____ HIV/AIDS	_____ Mental Health
_____ Sexually Transmitted Diseases	_____ Alcohol/Drug Abuse
	_____ Reproductive Care

**Minors: In accordance with Washington State law, a minor patient's signature is required NOT the parent/guardian signature regarding specific consents described above.**

Date	Signature of patient (minors 13-17) or representative	Relationship if not Patient
	<input type="checkbox"/> Check if patient is a minor	

\*Records concerning substance treatment and/or sexually transmitted diseases may NOT be redisclosed by you unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by regulation (42 CFR Part 2 and RCW 70.24). An authorization for the release of medical or mental health information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse Patient. Unless otherwise indicated, this release specifically allows the disclosure of mental health/psychological treatment (45 CFR Parts 160 and 164); drug/alcohol or other substance treatment (42 CFR Part 2); and the Health Insurance Portability Accountability Act of 1996 ("HIPAA") and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

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 must revoke my permission in writing and may do so by completing and signing the Revocation of Authorization form, available at the medical office; b) If I revoke my permission, it will not affect any actions already taken by **PCHS** based on this permission; and c) I may not be able to revoke this permission if the purpose of it was to obtain insurance.

Once **PCHS** has disclosed health information, the recipient may re-disclose it in some situations. Privacy Laws may no longer protect the information.

My permission expires on \_\_\_\_\_ (date or event). Written authorization will be needed unless other wise indicated. (rv.07/2018)