Peninsula Community Health Services

Provides accessible, affordable, compassionate, quality health care 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:

INFORMATION TO BE RELEASED BY:

Peninsula Community Health Services
P. O. Box 960
Bremerton, WA 98337
Fax: (360) 874-5595
Phone: (360) 377-3776

INFORMATION TO BE RELEASED TO: **(Must supply contact information)**

NAME: _____
ORGANIZATION: _____
ADDRESS: _____
CITY, STATE ZIP: _____
Phone & Fax: _____

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

RELEASE REQUIRING SPECIFIC CONSENT: My signature below gives you permission to release ANY and ALL confidential information relating to testing, diagnosis or treatment. Per 42 CFR **(See * Statement Below)** I understand I need to initial any of the following categories of confidential information or, it **WILL NOT** be released.

_____ HIV/AIDS
_____ Sexually Transmitted Diseases
_____ Mental Health
_____ Alcohol/Drug Abuse
_____ Reproductive Care

Minors: In accordance with Washington State law, a minor patient's signature is required in order to release information described above.
*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.

Date | Signature of patient (minors 13-17)or representative | Relationship if not Patient

☐ 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 realease 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.