WOODCREEK HEALTHCARE

Records Custodian
10004 204th Ave E, Ste 1300
Bonney Lake, WA 98391
Phone 253.848.8797
Fax 253.826.1264

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name ______________________________ Date of Birth ______________
Last First MI mm/dd/yyyy

I Authorize WOODCREEK HEALTHCARE to

❑ Release Health Care Information To ❑ Obtain Health Care Information From ❑ Exchange Health Care Information With

Name ______________________________
Name (Provider, Office, Hospital, School, Individual Entity, or Class of Persons)

Address ______________________________ Phone ______________
Street or P.O. Box

______________________________ Fax ______________
City State ZIP

The Following Communication or Records are Requested *(Check all that apply)*

❑ All health care information in my medical record ❑ Verbal, telephone, or email communication

❑ Health care information in my medical record relating to the following treatment, condition, or date(s) of treatment ______________

____

❑ Other, please specify including date(s) ______________

Protected Information - Check the item(s) that you want EXCLUDED from the records to be released:

(See "Release of Information of a Minor" requirements below.)

❑ Sexually transmitted disease (including HIV) ❑ Psychiatric disorders/mental health ❑ Substance abuse ❑ Birth control and prenatal care services

I understand the information to be released will NOT include the items I have marked above. I authorize the release or disclosure, written or verbal of this type of information.

______________ ______________ ______________
Signature of Minor Patient Printed Name of Patient Date

Reason(s) for this Authorization *(Check all that apply)*

❑ Attorney ❑ Insurance ❑ Doctor ❑ Billing ❑ Personal ❑ Transfer of Care ❑ Other, specify ______________

This authorization expires 90 days from the date signed unless noted below.

❑ On this date ______________ ❑ On this event, please specify ______________
mm/dd/yyyy

I want a copy of my health record *(For records released to you)*

❑ Secure Electronic Delivery
"Your Access" Portal Registration Required

❑ Mailed (CD)

❑ Pickup at location: ______________

Patient Rights

I understand I do not have to sign this authorization in order to receive health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health care information for a third party. I also understand Woodcreek will in no way use this information for marketing purposes.

I may revoke this authorization in writing. If so, it would not affect any actions already taken by Woodcreek Healthcare based upon this authorization. I may not be able to revoke this authorization if it's purpose was to obtain insurance. Two ways to revoke this authorization are to fill out a revocation form, or submit a request in writing to Woodcreek Healthcare.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

***Release of Information of a Minor** -- The minor is **required** to sign this release, if the following conditions are met:*

Any age: ❑ Birth control and prenatal care records OR ❑ The minor is legally emancipated or married to either an adult or an emancipated minor

14 years of age or older: ❑ Sexually transmitted disease (including HIV) records

13 years of age or older: ❑ Mental health records OR ❑ Substance abuse records

______________ ______________
Signature of ❑ Parent or Guardian OR ❑ Minor Patient if condition(s) above are met. Printed Name

______________ ______________
Relationship to Patient Date

Please return this completed form to the address listed above.