JAMESTOWN
FAMILY HEALTH CLINIC

AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

Previous Name_____ *Format of requested records:* □ *Paper* □ *Electronic (Compact Disk)*

INFORMATION TO BE RELEASED FROM:

Jamestown Family Health Clinic
808 N. 5th Ave, Sequim, WA 98382
PH: 360-683-5900 FAX: 360-582-4800

INFORMATION TO BE RELEASED TO:

_____
Organization/Provider

_____
Mailing Address City St ZIP

_____
Phone Fax

PURPOSE OF RELEASE: □ Transfer of Care □ Continuing Care □ Personal Use □ Legal □ Insurance
□ Mutual Exchange □ Other (specify) _____

INFORMATION TO BE RELEASED

☐ **Two years' worth of all medical records up to and including the most recent dates of service**. *Records to include: testing and diagnosis of HIV, sexually transmitted disease, psychiatric disorders/mental health, drug and/or alcohol use and treatment.*

☐ **Other:** *Specific health information relating to the following treatment or dates*

_____

_____

To ***EXCLUDE*** any of the following information, **INITIAL** all that apply

_____ Mental Health or Psychiatric Disorder _____ STD or STI (Sexually transmitted disease or infection)
_____ Drug and/or Alcohol abuse and Treatment _____ HIV/AIDS Virus

This authorization will expire 1 year from the date signed below unless another date or event is entered here_____

Patient Notice: I understand that if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal and state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes: HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from disclosing this information

I understand that I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing to Jamestown Family Health Clinic Attn: Administration. If I did, it would not affect any actions already taken based upon this authorization.

_____

Signature of Patient or Legally Responsible party DATE (MM/DD/YYYY)

_____

Relationship to patient, if not signed by patient

SIGNATURE OF MINOR PATIENT REQUIRED FOR THE FOLLOWING RECORDS

A minor patient's signature is required to release the following information: 1) Information related to reproductive care such as birth control, pregnancy related services and sexually transmitted diseases or infections, including HIV/AIDS (age 14 and older); 2) Substance abuse and mental health treatment (age 13 and older).

_____

Signature of Minor Patient DATE (MM/DD/YYYY)