JAMESTOWN
FAMILY HEALTH CLINIC

AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION

Patient Name (Print)_____**Date of Birth**_____

Previous Name (Print)_____ **Phone Number**_____

INFORMATION TO BE RELEASED FROM:

_____
Organization/Provider (Required)

_____
Mailing Address City (Required) State (Required) ZIP

_____
Phone (Required) Fax

INFORMATION TO BE RELEASED TO:

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

PLEASE DO NOT SEND RUN-ON RECORDS
OR RECORDS PRINTED FRONT & BACK

PURPOSE OF RELEASE: □ Transfer □ Continuation of Care □ Mutual Exchange

INFORMATION TO BE RELEASED:

☐ **Most recent 2 years of all medical records, as well as the following reports regardless of date.**

- *Colonoscopy Reports and Pathology*
- *Dexa/Bone Density Study*
- *Mammogram/Breast Imaging*
- *PAP Results*

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

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

***INITIAL ONE OF THE BELOW**

____ **YES,** I consent to release this information to my Jamestown provider.

____ **NO**, I do not consent to the release of this information, and I understand this may affect my care.

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 SIGNED (MM/DD/YYYY)**

_____

Printed Name **Relationship to patient, if not signed by patient**

SIGNATURE OF MINOR PATIENT REQUIRED FOR THE FOLLOWING RECORDS-Age 13/14 and older

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).

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