Peninsula Community Health Services

PERMISSION TO RELEASE HEALTH CARE INFORMATION – OUTGOING RECORDS

Patient's Full Name:					
Date of Birth: / /		Previous Name (if applicable):			
I HEREBY REQUEST AND GIVE MY PERMISSION TO RELEASE THE FOLLOWING INFORMATION					
INFORMATION TO BE RELEASED FROM Peninsula Community Health Services					
PO BOX 960	Bremerton	WA	98337	Phone: 360-377-3776	Fax: 360-874-5595
Reason for Request: ☐ Legal ☐ Insurance ☐ Personal Use ☐ Continuing Care ☐ Other: _____					

INFORMATION TO BE RELEASED TO (must provide contact information)		
Name:	Organization:	
Address:		
City:	State:	Zip:
Phone:	Fax:	

INFORMATION TO BE RELEASED (choose 1)

☐ Information from the past 2 years of care
☐ Health information from _____ to _____
☐ Specific health information about _____

*Restrictions: Only records originating from this healthcare system 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 or representative:	
Relationship if not the patient:			

RELEASE REQUIRING SPECIFIC CONSENT

My signature above gives you permission to release **ANY and ALL** confidential information relating to testing, diagnosis or treatment. Per 42 CFR part 2 (See * Statement Below) I understand if I initial any of the following categories of confidential information it **WILL NOT** be released.

_____HIV/AIDS	_____MENTAL HEALTH	_____SUBSTANCE USE
_____SEXUALLY TRANSMITTED DISEASES	_____REPRODUCTIVE HEALTH	

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 the patient:			

**Records concerning substance use treatment and/or sexually transmitted diseases may NOT be disclosed 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 a substance use patient. Unless otherwise indicated, this release specifically allows the disclosure of mental health/psychological treatment (45 CFR Parts 160 and 164); substance use treatment (42 CFR Part 2); and the Health Insurance Portability Accountability Act of 1996 ("HIPAA") and cannot be disclosed without your written consent unless otherwise provided for in the regulations.*

I understand that I do not have to sign this authorization in order to get healthcare 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.

I understand that the requested records may contain reproductive health care information. I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii). I understand that I may be subject to criminal penalties under 42 USC 1320d-6 if I knowingly violate HIPAA by wrongfully obtaining or disclosing PHI.

Expires one year from date authorization is signed, unless specified otherwise: _____