Patient Information

Name *(Please print full name)*:_____ Date of Birth: _____

Address: _____ Phone #: _____

MRN: _____ Email: _____

Release format: ❑ Paper Copy ❑ Electronic Delivery ❑ Electronic Hard Copy (CD-ROM) ❑ Verbal/Oral discussions

I authorize the mutual exchange of information between the listed entities. **Initials** _____

Request information from listed provider: ❑ MultiCare Health System ❑ PACE ❑ Navos ❑ Greater Lakes

❑ Other: Name/Organization: _____

Phone: _____ Email: _____ Fax: _____

Address: _____

Send my information to: Name/Organization: _____

Phone: _____ Email: _____ Fax: _____

Address: _____

Purpose of Release: ❑ Health Care ❑ Personal ❑ Legal/Investigative/Judicial Action ❑ Billing ❑ Insurance

❑ Other: _____

What information should be released: _____

_____

Select type(s) of information that may be released.

MH = Mental Health
SUD = Substance Use Disorder

Routine Medical Records Sets----------OR----------Specific Medical Records Documents Only

❑ **Clinic Records** (Includes: Office Visit, Laboratory, Radiology, Medication Record, Immunization Record)
❑ **Hospital Records** (Includes: History and Physical, Discharge Summary, Operative Report, Consultations Emergency, Laboratory, Radiology)
❑ **Access Records**
❑ **Billing Records**
❑ Discharge Summary/Note
❑ History and Physical
❑ Operative Report
❑ Radiology Report
❑ Radiology Images and Films
❑ Laboratory Report
❑ Other (please specify): _____
❑ Pathology Report
❑ Emergency Report
❑ Immunization Record
❑ Nursing Notes
❑ Medication Notes
❑ Progress Notes/ Clinic Notes
❑ Rehab Therapy (PT/OT/ST)

❑ **MH** Intake/Admission Assessment
❑ **MH** Medication Records/Notes
❑ Medication/Psychiatric Evaluation
❑ **MH** Prog Notes/Group Notes
❑ Psychological Evaluation
❑ **MH** Treatment Summaries/Plans
❑ **MH** Letter/Summary of Client Treatment/Attendance
❑ **MH** Crisis/DCR Contact/ITA Notes
❑ **MH** Crisis Plans
❑ **MH** Discharge Summary
❑ **MH** Scheduling and Appointment Verification
❑ Participation in **MH/Medication** Appointments
❑ Financial/Demographic
❑ Lab Results
❑ School IEP/504 Plan/Classroom Rep

❑ **SUD** Assessment/Evaluation
❑ **SUD** Assessment Summary
❑ **SUD** Treatment Recommendations
❑ **SUD** Medication Assisted Treatment Record
❑ **SUD** Treatment Summaries/Plan
❑ **SUD** Compliance/Attendance Verification Reports
❑ **SUD** Progress/Group Notes
❑ Drug Panel Screen/UA Results
❑ **SUD** Crisis Plans
❑ **SUD** Discharge Summary/ Certification
❑ **SUD** Scheduling Appointment Verification Information
❑ Completion of Dept of Licensing On-Line Form

❑ Specific Dates of Service or Condition-related information: _____

_____

❑ Verbal communication about my medical history and care: _____

_____

Special information: I authorize the inclusion of the following information with this release **(initial all that apply)**

_____ Sexually transmitted Infections, including HIV/AIDS
_____ Psychiatric, mental or behavioral health information
_____ Substance Use Disorder (SUD) information
_____ Genetic information and indicators

**** * * NOTE: If this section is not completed, records of this type (if they exist), will not be released. * * ****

SIGNATURE REQUIRED ON PAGE 2

Patient Identification - Write in or attach patient label

Name:

MRN #:

CSN #:

Age / Sex & Gender:

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (PROTECTED HEALTH INFORMATION OR PHI)

MultiCare

87-8455-5e A (Rev. 6/22)

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (PROTECTED HEALTH INFORMATION OR PHI) *(continued)*

Your rights and other notices:

1. Once MultiCare releases your health information, the recipient may re-disclose that information and privacy laws may no longer protect it. Some information, such as substance use disorders or mental health may still be protected.
2. I can withdraw this authorization at any time (please refer to Revocation section below). If I withdraw my authorization it will not change actions that were already taken according to the authorization.
3. MultiCare does not require you to complete this authorization to receive healthcare or healthcare benefits. However, you must sign this authorization form when the purpose of healthcare services or research participation is to create or receive health care information.
4. I understand this request for records may result in charges. I understand I will be contacted with an estimate of those charges before the records are produced. More information on charges can be found at www.multicare.org/medical-records/.

Expiration:

This authorization is valid for 365 days from the date of signature or until the date or event specified here: _____

_____

Signature:

Patient/Representative: _____ Date/Time: _____

Legal Authority: _____ Minor Signature: _____

(Signature of the individual and date) *If co-signature is required for minors*

If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided.

Printed Name & Date: _____ Relationship: _____

REVOCATION

You may revoke this authorization in writing. You may call one of the departments listed or obtain the hospital address under Health Information Management (Medical Records) Locations on https://www.multicare.org/medical records. The revocation will be effective upon receipt, but will not apply to information that has already been released or to services already provided according to this authorization.

Inland Northwest Deaconess Hospital: 509-473-7421

Inland Northwest Rockwood Clinic: 509-342-3955

Inland Northwest Valley Hospital: 509-473-5431

Puget Sound MultiCare Hospitals: 253-403-2433

Greater Lakes Mental Health: 253-620-5150

Navos: 206-257-6609

MultiCare Behavioral Health: 253-697-8530

CONSENT FOR MINOR

A signature of a minor patient is required to release information concerning care for: (1) birth control and pregnancy-related care, (2) sexually transmitted disease information (including HIV/AIDS) if the minor is 14 or older, (3) substance use disorder diagnosis, treatment, or referral information (for capable minors under 13, both minor and guardian must consent), and (4) outpatient mental health information if the minor is 13 or older.

MULTICARE USE ONLY

- ❑ **Was the request completed and medical records released to an external provider? [ ] YES [ ] NO**
- ❑ **Was this request sent to an external provider or hospital to obtain medical records? [ ] YES [ ] NO**
- ❑ **Is this an authorization for verbal communications or ongoing discussion that only needs to be filed for reference? [ ] YES [ ] NO**

Patient Identification - Write in or attach patient label

Name:

MRN #:

CSN #:

Age / Sex & Gender:

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (PROTECTED HEALTH INFORMATION OR PHI)

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