MY RIGHTS

Once MultiCare discloses your health information, the recipient may re-disclose the information, and privacy laws may no longer protect your information. Federal and state laws may forbid sharing information about substance use disorders, sexually transmitted diseases, or mental health information without written consent of the patient.

I understand I can withdraw this consent form at any time except to the extent that action has been taken in reliance on it. Withdrawal requests must be submitted in writing to one of the following Health Information Management Departments listed below. Please contact the appropriate location for the address.

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, or enrollment); however, I do have to sign an authorization form when the purpose of health care services or research participation is to create health care information for a third party.

I understand I may be charged a fee for the copies. Cost information may be obtained by calling one of the phone number listed below.

REVOCATION OF CONSENT

You may revoke this consent 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 consent.

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

MULTICARE USE ONLY

❑ **Was this request completed and medical records given to the patient or released to an external provider? [ ] YES [ ] NO**

❑ **Was this request sent to an external provider or hospital to obtain medical records? [ ] YES [ ] NO**

SUBSTANCE USE DISORDER PROGRAM INFORMATION

Federal law (42 CFR Part 2) forbids any unauthorized disclosure or additional release of substance use disorder program information without the written consent of the person whose information it is. Capable minors under the age of 13 must consent to disclosures in addition to the parent or legal guardian. Federal rules limit any use of this information to criminally investigate or prosecute any substance use disorder patient. If information is being released to an entity or class of participants under a general designation, upon request, a list of entities the information was disclosed to will be provided according to 42 CFR Part 2.

MENTAL HEALTH SERVICES INFORMATION

State law forbids most disclosures of mental health information without specific written consent of the person whose information it is. The parent or legal guardian of a minor child may consent unless the minor patient is 13 or older. In that case, signature of the patient is required. A general authorization to release information is NOT enough for this purpose. (RCW 70.02.230)

SEXUALLY TRANSMITTED DISEASE INFORMATION (Includes HIV/AIDS)

State law forbids most disclosures of this information without specific written consent of the person whose information it is. The parent or legal guardian of the minor child may consent unless the patient is 14 or older. In that case, the signature of the patient is required. A general authorization to release information is NOT enough for this purpose. (RCW 70.02.220)

GENETIC INFORMATION

Genetic information includes many things, ranging from the results of any genetic testing, to your family's medical history. It also includes information about any genetic disorders or conditions you have or might have, as well as any genetic services you have received, are currently receiving, or have requested to receive. Also included is genetic information about a pregnancy, fetus, or embryo (including if in-vitro fertilization, or other assisted reproductive technology is used).

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 child and guardian must consent), and (4) outpatient mental health information if the minor is 13 or older.

PROHIBITION ON REDISCLOSURE OF HEALTH INFORMATION

Federal or state law may restrict the redisclosure or further use of information related to substance use disorders, sexually transmitted diseases, genetic information and information related to mental health.

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

Address: _____ **Age:** _____

Phone #: _____

❑ Paper Copy ❑ Electronic Copy (CD-ROM)

❑ Electronic Delivery: If you would like to receive your records electronically via our secure Patient Portal please provide your email address (This does not apply to requests for Radiology images and films): _____ .
You will be notified by email when your records are ready to be downloaded. For further information, please go to: https://patientportal.iodincorporated.com/MultiCare
(Charges may apply for records copied)

Purpose of Disclosure: ❑ Further Medical Care ❑ Personal ❑ Billing ❑ Insurance Eligibility/Benefits ❑ Transfer of Care
❑ Legal Investigation/Action ❑ Other: _____

Information may be disclosed by:

This request is for the medical records related to care provided at the following locations: Please select a box.

Puget Sound Hospitals and Clinics:

❑ Allenmore Hospital ❑ Auburn Medical Center ❑ Covington Medical Center ❑ Good Samaritan Hospital ❑ Mary Bridge Children's Hospital ❑ Tacoma General Hospital
❑ Specific MultiCare locations (clinics, urgent cares, RediClinic) (Pleases specify location(s)_____)
❑ All Puget Sound locations (clinics, urgent cares, RediClinic)
❑ All Puget Sound MultiCare Health System locations (includes all hospitals and clinics)

Inland Northwest Hospitals and Clinics:

❑ Valley Hospital ❑ Deaconess Hospital ❑ Rockwood Clinic (Pleases specify location(s)_____)
❑ All Inland Northwest outpatient locations (clinics, urgent cares, etc) ❑ All Inland Northwest Hospital locations and clinics

❑ **All MultiCare Health System locations**

❑ **Other:** _____

--OR--

❑ **External Provider, Name/Facility:** _____

Address: _____ Phone: _____ Fax: _____

Information may be disclosed to:

Name/Facility: _____

_____

Phone: _____ Fax: _____

Address: _____

Information to be disclosed:

Dates of Service and/or Conditions Treated: _____

_____

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

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)
❑ **Billing Records**

❑ Discharge Summary/Note
❑ History and Physical
❑ Operative Report
❑ Radiology Report
❑ Radiology Images and Films
❑ Laboratory Report
❑ Pathology Report
❑ Emergency Report
❑ Immunization Record
❑ Nursing Notes
❑ Medication Notes
❑ Progress Notes/Clinic Notes
❑ Rehab Therapy (PT/OT/ST)
❑ Other (please specify): _____

I authorize the release of the below information: (**Initial** all that apply) *See reverse side for details*

_____ HIV (AIDS virus)
_____ Sexually transmitted diseases
_____ Genetic information and indicators
_____ Psychiatric diagnosis or mental health
_____ Substance use disorder

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

***** If the records requested above will result in any charges, I understand I will be contacted with an estimate of those charges before the records are produced. MultiCare's charges for release of information vary depending upon the nature and extent of the records requested. For more information, please go to https://www.multicare.org/medical-records***

This Authorization Expires in 90 days: (Unless a date or event is specified here): Date/Event: _____

_____ _____ *Legal Authority: _____

Signature of Patient/Representative **Date/Time** **If signed by person other than the patient, print name and identify relationship.*

Patient Identification - Write in or attach patient label

Name:

MRN #:

CSN #:

Age / Sex:

CONSENT TO USE OR RELEASE MY HEALTH CARE INFORMATION

MultiCare

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