OVERLAKE MEDICAL CENTER & CLINICS
MultiCare

Health Information Management **Phone: 425-688-5643**
Fax: 425-467-3343

Authorization to Disclose Protected Health Information

Must be Completed Fully to Process

1. Patient Information: (Please print)

Patient Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

2. Records to be Disclosed: *Note that records may include information related to mental health, treatment of alcohol or drug abuse, sexual transmitted disease, AIDS/HIV diagnosis report, reproductive health care services and gender-affirming treatment.

[ ] Hospital visit notes	[ ] Reports of imaging (x-ray) or cardiology
[ ] Pertinent record (ED notes, encounter notes, imaging, lab, cardiac reports, pathology, surgical info)	[ ] Images of x-rays or cardiology (contact film library at 425-688-5564)
[ ] Clinic records (include name of clinic and/or provider)	[ ] Immunization records
[ ] Emergency department records	[ ] Billing records
[ ] Laboratory results	[ ] Other

3. Dates of Service for Records to Be Disclosed:

☐ All Dates **OR** ☐ From: _____ (Start Date) To: _____ (End Date)

4. Recipient Information:

Recipient: _____

Address: _____

State, Zip: _____

Phone: _____ Fax: _____

OVERLAKE MEDICAL CENTER & CLINICS
MultiCare

5. Format for Record Delivery

[ ] Upload the information to MyChart secure portal (must have a current MyChart account) (No Fee)
[ ] Mail paper copy to the address listed above. (Fees may apply)
[ ] Fax paper copy to the provider fax number listed above. (No Fee)
[ ] Copy the information to CD and mail to the address listed above. (Fees may apply)
[ ] Email the information via secure email to my email address listed above. (Fees may apply)
[ ] Email the information via PowerShare to my email address listed above. (No Fee)
[ ] Other _____

6. Purpose of Disclosure

[ ] Treatment or medical care
[ ] Insurance purposes or claims processing
[ ] Legal purposes or litigation
[ ] Employment requirements or verification
[ ] School or educational requirements
[ ] For personal records
[ ] Other _____

7. Other Important Information

I authorize the release of medical records as described above. Once my records are released, they may no longer be protected by federal or state privacy laws and may be subject to re-disclosure by the recipient.

This authorization expires one (1) year after I sign it, unless I specify an expiration date or event here: _____

_____

I further understand that this authorization may be revoked by me in writing at any time by contacting the HIM department, except to the extent that actions have already been taken in reliance on this authorization.

8. Signature and Consent

Signature: _____ Date: _____
(If signed by a personal representative of the patient, please complete the below)

Personal Representative's Name: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Executor of Estate*
*Please provide a copy of the legal documentation.

This authorization form can be submitted to the HIM department by mail or by fax:

Address: 1035 116th Ave NE, Bellevue, WA 98004 / Phone: 425-688-5643 / Fax: 425-467-3343

PLACE PATIENT LABEL HERE