Northwest Asthma & Allergy Center, P.S.

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION
from NW Asthma & Allergy

Patient name_____ Date of birth____/____/____

Previous name (if any) _____

I am requesting that NW Asthma & Allergy Center send a copy of my records to:

□ Myself via: □ Mail: _____

□ Fax _____ □ Email* _____

*If email is chosen: I understand that NW Asthma & Allergy email is unencrypted and I accept any risk associated with sending my records through email. _____ (initials required)

□ Other (name of practice/organization): _____

phone: _____ fax #: _____

Information to be Released (check all that apply)

□ Most recent 2 years office visits □ All office visits □ Testing

□ Other (specify): _____ □ Lab results □ Imaging reports (CT, xrays, etc)

******Please check **any** of the following health care information regarding testing, diagnosis, and treatment you wish to **exclude:**

□ HIV (AIDS virus) □ Sexually transmitted diseases

□ Psychiatric disorders/mental health □ Drug and/or alcohol use

Purpose of Release

Reason(s) for this authorization (check all that apply):

□ Self □ Doctor □ Attorney □ Insurance □ Other (specify) _____

This authorization ends:

□ On (date):_____ (max 90 days) □ When the following event occurs:_____ (max 90 days)

□ In 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment).

Release Requiring Specific Consent

Minors- A minor patient's signature is required in order to release the following information: 1) Conditions relating to reproductive care including but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS (age 14 and older); and 2) Mental health conditions (age 13 and older); and 3) Drug and alcohol abuse diagnosis or treatment (this information is subject to Federal Regulation 42 CFR Part 2). I specifically authorize information to be released as checked below:

□ Reproductive Care □ Sexually Transmitted Diseases (incl. HIV/AIDS) □ Mental Health/Illness □ Drug/Alcohol Abuse

_____ _____ _____

Signature of Minor Patient Date Time

Signature Required for Release of Information

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). 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. If I did, it would not affect any actions already taken by Northwest Asthma & Allergy Center based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Northwest Asthma and Allergy Center, Inc. Or
- Write a letter to Northwest Asthma and Allergy Center, Inc.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

Please fax completed form to: 206-527-2514, or email to info@nwasthma.com