

**AUTHORIZATION FOR RELEASE OF
HEALTHCARE INFORMATION
to NW Asthma & Allergy Center**

Patient name _____ Date of birth ____/____/____

Previous name (if any) _____

I am requesting that _____ (organization)

fax #: _____ phone #: _____

Send a copy of my healthcare records to **NW Asthma & Allergy Center**, fax (206) 523-0724

mailing address: 9725 Third Ave NE, Suite 500, Seattle, WA 98115

Information to be Released (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Most recent 2 years office visits | <input type="checkbox"/> All office visits | <input type="checkbox"/> Testing |
| <input type="checkbox"/> Other (specify): _____ | <input type="checkbox"/> lab results | <input type="checkbox"/> imaging (CT, xrays, etc) |

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

- | | |
|--|--|
| <input type="checkbox"/> HIV (AIDS virus) | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Psychiatric disorders/mental health | <input type="checkbox"/> Drug and/or alcohol use |

Purpose of Release**Reason(s)** for this authorization (check all that apply):

- | | | | | |
|-------------------------------|---------------------------------|-----------------------------------|------------------------------------|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> Doctor | <input type="checkbox"/> Attorney | <input type="checkbox"/> Insurance | <input type="checkbox"/> Other (specify) _____ |
|-------------------------------|---------------------------------|-----------------------------------|------------------------------------|--|

This authorization ends:

- | | |
|---|---|
| <input type="checkbox"/> On (date): _____ (max 90 days) | <input type="checkbox"/> When the following event occurs: _____ (max 90 days) |
| <input type="checkbox"/> 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:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Reproductive Care | <input type="checkbox"/> Sexually Transmitted Diseases (incl. HIV/AIDS) | <input type="checkbox"/> Mental Health/Illness | <input type="checkbox"/> 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)