

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

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* _____

Other (name of practice/organization): _____

phone: _____ fax #: _____

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 reports (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)

Please fax completed form to (206) 527-0535 or email it to forms@nwasthma.com