Authorization to Disclose (Release) Health Care Information

GroupHealth®

(1) Individual Information:

PRINT name of patient	Birth Date	GHC medical record number

(2) Information may be disclosed by: ____
Name of organization or person releasing information

____
Street Address, City, State, Zip

(3) Information may be disclosed to: ____
Name of organization or person to receive information

____
Street Address, City, State, Zip

(________)________________________ (________)________________________
Daytime phone Fax

(4) What kind of information do you want disclosed? (check ONE box, copy fees may apply)

☐ Information from the most recent 2 years of visits
☐ All information from date: _____/_____/______ to date: _____/_____/______
☐ Information regarding specific treatment, condition or other (specify): ______________________________
____

(5) Why are you asking for this health information to be released? (check ONE box)

☐ Attorney ☐ Insurance ☐ Doctor ☐ Medical Leave ☐ Personal ☐ Other (specify) ____________________

Authorization:
Information released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness. I give my specific authorization for this information to be released.

Rights:
Generally, Group Health Cooperative and any other entity covered by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. If this authorization is for purposes of determining enrollment, eligibility, underwriting or risk rating prior to enrollment, not signing or revoking this authorization may impact enrollment or benefit determinations by Group Health Cooperative. I may revoke this authorization in writing. Once the information I have authorized to be disclosed is disclosed, it may no longer be protected under health information privacy laws. If I revoke my authorization, it will not affect any actions already taken by Group Health Cooperative based upon this authorization.

(6) This authorization expires 90 days from the date signed or on the date or event indicated here:
____.

(7) SIGNATURE: ____ **DATE:** _____/_____/________
(Patient or Member, Guardian*, or Authorized Representative*).
[*Documentation may be required to prove authority to sign on behalf of the patient.]

(8) MINOR SIGNATURE: ____ **DATE:** _____/_____/________
(Signature of minor is also required if minor is age 13-17).

Instructions can be found on ghc.org

Staff Distribution: Western Washington to CSB-ROI if processing still required, SRC for scanning if already processed; Eastern Washington to CSO for processing and scanning

Instructions

1. Print name of patient, birth date and Group Health medical record number of patient for whom the medical records are being requested.
2. Print name of organization or person that is being asked to disclose copies of the records.
3. Print name, address and phone number of organization or person that is to receive the copies of the information.
4. Check one box to indicate what information is to be disclosed:
   a. Information for most recent 2 years of visits.
   b. All inpatient, outpatient and ambulatory surgery visits for the specific time frame indicated.
   c. All records related to the course of treatment, diagnosis, procedure or condition indicated.
5. Check the box that applies to the reason the records are being requested.
6. Indicate date for the authorization to expire if it is to be different than 90 days from date of signing.
7. Sign and indicate date signed.
8. Minors between ages of 13 and 17 must authorize the release of certain information concerning the minor.

Charges

Group Health members can directly view and print some of their health information via MyGroupHealth which is accessible on the Group Health website at ghc.org. There is no charge for copying your medical records if you have the copies sent directly to a health care facility or provider for continuing or transfer of care. If you are requesting copies of medical records for yourself, you will get the first six pages free of charge. Additional pages will result in a copy fee being applied. In addition, postage and sales tax may be charged. You may be invoiced or required to pay applicable fees prior to obtaining the copies. Payment is otherwise due upon receipt of your copies. If charges exceed $25, payment may be required prior to receipt. Information disclosed pursuant to this authorization will not be redacted. Additional fees may apply if redaction is required.

Contact the appropriate department listed below to request your copies of your medical record, for information about copy charges and/or questions related to copying health information from your Group Health medical record. You can also find information on the Group Health website at ghc.org.

Western Washington
Centralized Release of Information
125 16th Ave E
Seattle, WA 98112

206-326-3058 or 1-866-656-4184 (phone)
206-326-2599 (fax)

Eastern Washington
Centralized Health Information Management
521 E Sprague Ave
Spokane, WA 99202

509-241-7824 (phone)
509-232-3127 (fax)