Authorization for Release of Confidential Health Information

TouchStone HEALTH CLINIC
Where healing begins

I Authorize Release of My Health Information

Name: _____ Date of Birth: _____

Daytime Phone: _____

Are you authorizing release of your own records? ❑ Yes ❑ No

** If not, what is your relationship to the patient?_____

** Release of certain medical information requires a minor's consent. Persons 13-17 yrs - info pertaining to substance abuse and mental health. Persons 14-17 yrs - info pertaining to STIs/STDs, HIV and AIDS. Other laws may apply.

To Release Information Including:

❑ Complete Chart Record *(does not include billing information or radiographic images)*

❑ Chart Notes: ❑ All ❑ Specify: _____

❑ Labs/Reports/Imaging: ❑ All ❑ Specify:_____

❑ Other:_____

Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to: (check the accompanying box(s) below to EXCLUDE the information from authorization)

❑ Substance abuse ❑ Mental Health conditions/psychotherapy ❑ Sexually Transmitted Infections ❑ HIV/AIDS

To Be Released From:

❑ TouchStone Health Clinic ❑ Facility/Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

To Be Released To:

❑ TouchStone Health Clinic ❑ Self (please provide current address, **fee may apply)**

❑ Facility/Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

For the Purpose of: ❑ Adjunctive/Concurrent Care ❑ Transfer of Care ❑ Other: _____

I understand that unless revoked this authorization is valid for 1 year from the date of signing. **I understand** that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document. **I understand** that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law. **I also understand** that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected. **I understand** that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing. I may call the clinic at 360-788-4228 to inquire about revoking authorization. I understand that if I request records for personal use, to hand-carry to another health provider, or for parties not involved in my health care, there may be a charge. 'Non-emergency' release of records may take up to 15 working days. Emergency requests will be given priority processing. 'Emergency' status applies only to release of records directly to another healthcare provider for urgent patient care. There is no charge to release records to another healthcare provider.

Patient's Signature: _____ Date _____

Rep./Guardian's Signature: _____ Date: _____