

Patient Information

Name (Please print full name): _____ Date of Birth: _____

Address: _____ Phone #: _____

MRN: _____ Email: _____

Release format: Paper Copy Electronic Delivery Electronic Hard Copy (CD-ROM) Verbal/Oral discussions

Information to be released from: MultiCare Health System Navos only Greater Lakes only

Other: Name/Organization: _____

Phone: _____ Email: _____ Fax: _____

Address: _____

Information may be released to:

Name/Organization: _____

Phone: _____ Email: _____ Fax: _____

Address: _____

Purpose of Release: Health Care Personal Legal/Investigative/Judicial Action Billing Insurance

Other: _____

What information should be released: _____

Select type(s) of information that may be disclosed.

MH = Mental Health

SUD = Substance Use Disorder

Routine Medical Records Sets-----OR-----Specific Medical Records Documents Only

Clinic Records (Includes: Office Visit, Laboratory, Radiology, Medication Record, Immunization Record)

Hospital Records (Includes: History and Physical, Discharge Summary, Operative Report, Consultations Emergency, Laboratory, Radiology)

Billing Records Pathology Report

Discharge Summary/Note Emergency Report

History and Physical Nursing Notes

Operative Report Medication Notes

Radiology Report Progress Notes/ Clinic Notes

Radiology Images and Films Rehab Therapy (PT/OT/ST)

Laboratory Report

Other (please specify): _____

MH Intake/Admission Assessment

MH Medication Records/Notes

Medication/Psychiatric Evaluation

MH Prog Notes/Group Notes

Psychological Evaluation

MH Treatment Summaries/Plans

MH Letter/Summary of Client Treatment/Attendance

MH Crisis/DCR Contact/ITA Notes

MH Crisis Plans

MH Discharge Summary

MH Scheduling and Appointment Verification

Participation in MH/Medication Appointments

Financial/Demographic

Lab Results

School IEP/504 Plan/Classroom Rep

SUD Assessment/Evaluation

SUD Treatment Recommendations

SUD Medication Assisted Treatment Record

SUD Treatment Summaries/Plan

SUD Compliance/Attendance Verification Reports

SUD Progress/Group Notes

Drug Panel Screen/UA Results

SUD Crisis Plans

SUD Discharge Summary

SUD Scheduling Appointment Verification Information

Completion of Dept of Licensing On-Line Form

Specific Dates of Service or Condition-related information: _____

Verbal communication about my medical history and care: _____

Special information: I authorize the inclusion of the following information with this release **(initial all that apply)**

_____ Sexually transmitted Infections, including HIV/AIDS _____ Psychiatric, mental or behavioral health information

_____ Substance Use Disorder (SUD) information _____ Genetic information and indicators

*** NOTE: If this section is not completed, records of this type (if they exist), will not be released. ***

SIGNATURE REQUIRED ON PAGE 2

Patient Identification - Write in or attach patient label

Name: _____

MRN #: _____

CSN #: _____

Age / Sex & Gender: _____

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (PROTECTED HEALTH INFORMATION OR PHI)



AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (PROTECTED HEALTH INFORMATION OR PHI) (continued)

Your rights and other notices:

1. Once MultiCare releases your health information, the recipient may re-disclose that information and privacy laws may no longer protect it. Some information, such as substance use disorders or mental health may still be protected.
2. I can withdraw this authorization at any time by emailing the address listed below. If I withdraw my authorization it will not change actions that were already taken according to the authorization.
3. MultiCare does not require you to complete this authorization to receive healthcare or healthcare benefits. However, you must sign this authorization form when the purpose of healthcare services or research participation is to create or receive health care information.
4. I understand this request for records may result in charges. I understand I will be contacted with an estimate of those charges before the records are produced. More information on charges are can be found at www.multicare.org/medical-records/.

Expiration:

This authorization is valid for 365 days from the date of signature or until the date or event specified here: _____

Signature:

Patient/Representative: _____ Date/Time: _____

Legal Authority: _____ Minor Signature: _____
(Signature of the individual and date) If co-signature is required for minors

If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided.

Printed Name & Date: _____ Relationship: _____

REVOCATION

You may revoke this authorization in writing. You may call one of the departments listed or obtain the hospital address under Health Information Management (Medical Records) Locations on <https://www.multicare.org/medical-records>. The revocation will be effective upon receipt, but will not apply to information that has already been released or to services already provided according to this authorization.

Inland Northwest Deaconess Hospital: 509-473-7421

Greater Lakes Mental Health 253-620-5150

Inland Northwest Rockwood Clinic: 509-342-3955

Navos: 206-257-6609

Inland Northwest Valley Hospital: 509-473-5431

MultiCare Behavioral Health 253-697-8530

Puget Sound MultiCare Hospitals: 253-403-2433

CONSENT FOR MINOR

A signature of a minor patient is required to release information concerning care for: (1) birth control and pregnancy-related care, (2) sexually transmitted disease information (including HIV/AIDS) if the minor is 14 or older, (3) substance use disorder diagnosis, treatment, or referral information (for capable minors under 13, both minor and guardian must consent), and (4) outpatient mental health information if the minor is 13 or older.

MULTICARE USE ONLY

- Was the request completed and medical records released to an external provider? [] YES [] NO
- Was this request sent to an external provider or hospital to obtain medical records? [] YES [] NO
- Is this an authorization for verbal communications or ongoing discussion that only needs to be filed for reference?
[] YES [] NO

Patient Identification - Write in or attach patient label

Name:

MRN #:

CSN #:

Age / Sex & Gender:

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION (PROTECTED HEALTH INFORMATION OR PHI)

MultiCare 

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