



# INTERFAITH COMMUNITY HEALTH CENTER

medical • dental • pharmacy  
behavioral health

220 Unity Street  
Bellingham WA 98225

Phone: 360.676.6177  
Toll Free: 877.235.6850  
Fax: 360.671.3574

## AUTHORIZATION TO OBTAIN OR DISCLOSE HEALTH CARE INFORMATION

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_

SSN: \_\_\_\_\_

<i>Release records from:</i>		<i>Release records to:</i>	
Facility/Name: _____	Address: _____	Facility/Name: _____	Address: _____
Phone or Fax #: _____		Phone or Fax #: _____	

### You may use or disclose the following health care information (check all that apply):

- All health care information in my record, including testing and diagnosis for HIV, sexually transmitted diseases, psychiatric disorders/mental health, drug and/or alcohol use. Send two years worth of records up to and including the most recent dates of service.
- Specific health care information in my record relating to the following treatment or dates:  
\_\_\_\_\_

### Do NOT send records regarding (check any that apply):

- HIV/AIDS
- Psychiatric disorders/mental health
- Other \_\_\_\_\_
- Sexually transmitted diseases
- Drug and/or alcohol use

### Reason (s) for this authorization (check all that apply):

- At Patient Request
- Patient Personal Use (a fee may be required)
- Transfer of Care
- Mutual Exchange, no paper records needed at this time
- Verbal Exchange of Information
- Other (specify) \_\_\_\_\_ Legal? Insurance?

### This authorization ends (Please check ONE of the following options):

- in 90 days from the date signed
- one year from the date signed
- other: \_\_\_\_\_  
(No longer than one year from date signed)

### Patient Notices

I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal and state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information

I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations or if the services related to the information to be disclosed are performed solely for the purpose of providing that information to someone else.

I may revoke this authorization at any time by notifying the Health Information Management/Medical Records Department of Interfaith Community Health Center. However, any such revocation will not apply to any activity undertaken based on this authorization.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Requesting Provider

Date Sent \_\_\_\_/\_\_\_\_/\_\_\_\_ Initials \_\_\_\_  
Faxed \_\_\_\_ Mailed \_\_\_\_ Patient Pick Up \_\_\_\_  
Scan/File Only \_\_\_\_