NEW Health

Administrative Office
PO Box 808
Chewelah, WA 99109

509-935-6001
800-829-6583
Fax: 855-211-4215

AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION

PATIENT INFORMATION (PLEASE PRINT):

Last Name:_____ First Name: _____ MI _____

Birthdate:_____ Social Security #:_____ Phone: _____

Address:_____ City:_____ State:_____ Zip:_____

INFORMATION TO BE RELEASED FROM (PLEASE PRINT):

Organization Name: _____

Address (including city/state/zip): _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED TO (PLEASE PRINT):

Organization/Provider /Person Name: _____

Address (including city/state/zip): _____

Phone: _____ Fax: _____

MAY USE OR DISCLOSE HEALTH CARE INFORMATION REGARDING TESTING, DIAGNOSIS AND/OR TREATMENT FOR: *(check all that apply)*

- ☐ Complete Chart (for the last 3 years)
- ☐ Consults
- ☐ Immunization Record
- ☐ Other: _____

I UNDERSTAND THAT MY RECORDS MAY CONTAIN HIGHLY SENSITIVE INFORMATION. I GIVE MY SPECIFIC AUTHORIZATION FOR THESE RECORDS TO BE RELEASED: (*check all that apply & initial each*)

- ☐ Psychiatric Disorders/Mental Health _____
- ☐ HIV (AIDS Virus) _____
- ☐ Other (Specify):_____
- ☐ Sexually Transmitted Disease (s) _____
- ☐ Drug and/or Alcohol Use _____

THE PURPOSE FOR WHICH THIS DISCLOSURE IS BEING MADE IS: *(check one of the following)*

☐ Attorney/Legal* ☐ Insurance* ☐ Personal* ***Please be aware that medical record copy charges may apply.***

☐ Transferring Care *Please indicate reason below*:

☐ Moving ☐ Provider no longer at NEW Health ☐ Insurance change

☐ Dissatisfaction with provider/practice

May NEW Health to contact you regarding reason for transfer _____ (yes / no)?

Please note: All pending lab tests and orders will be cancelled upon notification of patient's intent to transfer care to a facility or provider outside of NEW Health.

PREFERRED FORMAT, PLEASE CHECK: ☐ Electronic ☐ CD ☐ Jump Drive (please provide drive) ☐ Paper
DELIVERY METHOD: ☐ Pickup ☐ Mail

AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION

MY RIGHTS:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). This authorization will expire **90 days** from the date signed. However, I do have to sign an authorization form:

- To receive health care when the purpose is to create health care information for a third party.
- To participate in a research study or marketing practices.

I understand that the confidentiality of these records will be protected by **NEW HEALTH PROGRAMS**. These records cannot be disclosed without written consent, except as provided for under Federal or State of Washington laws. I may revoke this authorization in writing. If I do, it will not affect any actions already taken. 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 of Authorization to Use or Disclose Health Care Information form. A form is available from **NEW HEALTH PROGRAMS**.
- Write a letter to **NEW HEALTH PROGRAMS**.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I release **NEW HEALTH PROGRAMS** of any liability if the recipient of disclosed information from this authorization inadvertently or purposely disclosed it.

I understand that my **EXPRESS CONSENT** is required for **NEW HEALTH PROGRAMS** to release information relating to sexually transmitted diseases, HIV/AIDS, contraception, pregnancy, sterilization, mental health conditions and/or drug/alcohol abuse. If I have been tested, treated or diagnosed in connection with any of these conditions, **NEW HEALTH PROGRAMS** is **SPECIFICALLY** authorized to release to the person or entity named above all information of medical/dental records relating to such diagnosis, testing or treatment.

As required by law, a patient who has reached his or her fourteenth birthday may authorize disclosure in connection with treatment of the above mentioned conditions. Minors have statutory and case law protection of their right to privacy regarding these decisions pertaining to their own bodies and health care, and the above information will not be released to anyone, including their parents or legal guardian, without his or her consent.

Patient or Legally Authorized Representative Signature	Date	Time

Printed Name if Signed on Behalf of the Patient	Relationship (Parent, Legal Guardian, Etc.)