NEW Health

Administrative Offices 509-935-6001
PO Box 808 800-829-6583
Chewelah, WA 99109

AUTHORIZATION TO USE OR DISCLOSE HEALTHCARE 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: _____

Clinic 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 2 years) ☐ Billing Records

☐ Consultations ☐ FMLA Documentation

☐ Immunization Records ☐ Radiology Images

☐ Other (Specify): _____

I UNDERSTAND THAT MY RECORDS MAY CONTAIN <u>HIGHLY SENSITIVE INFORMATION</u>. (Check each record you give your **<u>SPECIFIC AUTHORIZATION</u>** to be released).

☐ Psychiatric Disorders/Mental Health ☐ Sexually Transmitted Disease(s)

☐ HIV/AIDS Virus ☐ Drug and/or Alcohol Use ☐ Other*

*If you checked "other", please specify what information you are authorizing for release:

_____

THE PURPOSE FOR WHICH THIS DISCLOSURE IS BEING MADE IS: (Check <u>one</u> of the following).

☐ Attorney/Legal* ☐ Insurance* ☐ Personal*

**Please be aware that medical record copy charges may apply*

☐ Continuation of Care ☐ Second Opinion ☐ Transferring Care

<u>If transferring care, please indicate reason:</u>

☐ Moving ☐ Insurance Change ☐ Provider left NEW Health

☐ Dissatisfaction with Provider/Practice ☐ Other: _____

May NEW Health contact you regarding reason for transfer? ☐ Yes ☐ No

<u>Please note:</u> 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, and all prescription refills will be cancelled after 30 days.

AUTHORIZATION TO USE OR DISCLOSE HEALTHCARE INFORMATION

MY RIGHTS:

I understand that I do not have to sign this authorization to receive healthcare (including treatment, payment, enrollment, or benefits eligibility).

I understand that the confidentiality of my records will be protected by NEW Health and my healthcare information cannot be disclosed without my written consent, except as provided under Federal or State law. If healthcare information is properly disclosed according to the terms of this Authorization, I understand that NEW Health is **NOT LIABLE** if the authorized recipient inadvertently or purposely discloses the information.

This Authorization will be deemed valid for **ONE YEAR** unless **EXPRESSLY REVOKED** in writing. Authorization may be revoked at any time unless the authorization is required to secure payment for healthcare services already rendered or substantial actions were taken in reliance on the authorization. Authorization will expire if you terminate or transfer care.

There are two ways to revoke authorization:

- Revocation of Authorization to Use or Disclose Health Care Information Form. This form will be provided by NEW Health upon request
- A letter to NEW Health expressly requesting revocation

I understand that my **EXPRESS CONSENT** is required for NEW Health to release information relating to sexually transmitted diseases, HIV/AIDS, contraception, pregnancy, sterilization, mental health conditions, and/or drug or alcohol abuse. If I have been tested, treated or diagnosed in connection with any of these conditions, NEW Health is **SPECIFICALLY AUTHORIZED** to release to the person or entity named above the medical or dental records relating to such diagnosis, testing, or treatment. Information pertaining to these specific circumstances will not be released to anyone, including parents or legal guardians of minors 14 years or older, without **EXPRESS CONSENT.**

Patient or Legally Authorized Representative Signature

Date

Printed Name of Legally Authorized Representative

Relationship (parent, legal guardian, etc.)