OLYMPIC MEDICAL CENTER

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Olympic Memorial Hospital | Olympic Medical Physicians | Olympic Medical Home Health

PATIENT INFORMATION

Patient Name (printed):_____ Previous Name(s):_____

Date of Birth:_____ Daytime Telephone Number:_____

SEND INFORMATION TO: (please be specific)

Provider Name/Organization:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone #:_____ Fax #:_____

INFORMATION TO BE RELEASED FROM: (please be specific)

Provider Name/Organization:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone #:_____ Fax #:_____

PURPOSE OF DISCLOSURE

❑ Transfer of Care ❑ Self ❑ Specialist ❑ Other _____(must complete)

INFORMATION TO BE DISCLOSED

❑ Medical Records from last two years

❑ Limited Health Information or Documentation Dates of Service:_____

❑ Complete Medical Chart Contents

❑ Other_____ Expiration Date (or event)_____

(No more than 90 days forward)

CONSENT TO DISCLOSE

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA of 1996.

_____ _____ _____

Date Signature of patient or representative Relationship to patient

DISCLOSURES REQUIRING SPECIAL CONSENT

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for (Please initial beside the specific information to disclose):

_____ HIV/AIDS Virus _____ Mental Health/Psychiatric Disorders

_____ Sexually Transmitted Diseases _____ Drug, Alcohol Abuse/Treatment

_____ _____ _____

Date Signature of patient or representative Relationship to patient

FOR FACILITY USE ONLY

Date Received:_____ Date Information Released:_____ Chart #:_____

Person/Department Sending Records: _____

OLYMPIC
MEDICAL CENTER

NOTICE TO PATIENTS
PHOTOCOPY CHARGES FOR MEDICAL RECORDS

Olympic Memorial Hospital | Olympic Medical Physicians | Olympic Medical Home Health

We will be happy to provide copies of your medical records per your request. Olympic Medical Center contracts with IOD Incorporated, P.O. Box 52930, Bellevue, WA 98105, a professional medical record copying service, to ensure that your copies are available to you as quickly as possible.

If your request for release of information is to another Healthcare Provider (for continuing care), there will be no charge for the processing of your request. If the release is for other reasons, there may be a charge as outlined below.

The ability to charge for the copying of medical records, to cover the costs of labor and supplies, has been developed by the Washington State Legislature and is outlined in RCW 70.02.

Prior to copying your records, IOD Incorporated would like you to know that there may be a fee for the copies made. IOD Incorporated will contact you with the prepayment amount if necessary.

1-9 pages = No charge
10-30 pages = $1.04 per page
31+ pages = $.79 per page
Applicable tax and postage
Reasonable cost of reproduction on to other media type

Please complete the

Authorization to Disclose Protected Health Information

AND this *Notice to Patients Photocopy Charges for Medical Records*

and mail to:

Olympic Medical Center
Attn: Medical Records / ROI
939 Caroline Street
Port Angeles, WA 98362
(360) 417-7135

I understand that there may be a charge to copy my medical records and that IOD Incorporated may require prepayment.

Patient Signature:_____ Date:_____

Printed Name:_____

Address:_____

_____

Phone Number:_____