AUTHORIZATION TO DISCLOSE (RELEASE) HEALTH CARE INFORMATION

1. **Patient Information**

   PRINT Name of Patient/Employee ______________________________

   Address ______________________________

   Telephone ______________ Birth Date ______________

2. **Information to be Released From**

   Organization, physician, or provider ______________________________

   Address ______________________________

   City, State, Zip ______________________________

   Phone ______________ Fax ______________

3. **Information to be Released To**

   Northwest Educational Service District 189 (NWESD)
   Attention: ______________
   1601 R Avenue, Anacortes, WA 98221
   Phone ______________ Fax ______________

4. **Purpose of Release**

   ☐ At my request ☐ Other (specify) ______________

5. **Type of Information to be Released**

   ☐ All health care information in my medical record

   ☐ Health care information from date: ______________ to date: ______________

   ☐ Health care information relating to the following treatment of condition: ______________

   ____

   ☐ Billing records ☐ Radiology images (specify) ______________

6. **Patient Authorization**

   I understand that:

   - Any entity covered by the Health Insurance Portability and Accountability Act of 1996 may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
   - I may revoke this authorization in writing. If I revoke my authorization, it will not affect any actions already taken based upon this authorization.
   - Information released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness. I give my specific authorization for this information to be released.
   - Once health care information is disclosed, NWESD will protect confidentiality under health information privacy laws.

7. **Signature**

   ______________________________ ______________

   Patient/employee or legally authorized representative Date

8. **This authorization expires** ninety (90) days from the date signed OR on the date or event indicated here:

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