

Health Information Management Phone: 425-688-5643
Fax: 425-467-3343

Authorization to Disclose Protected Health Information

Must be Completed Fully to Process

1. Patient Information: (Please print)

Patient Name: _____ Birthdate: _____
Address: _____ City: _____ State: _____ Zip: _____
Email: _____ Phone: _____

2. Records to be Disclosed: *Note that records may include information related to mental health, treatment of alcohol or drug abuse, sexual transmitted disease, AIDS/HIV diagnosis report, reproductive health care services and gender-affirming treatment.

☐ Hospital visit notes	☐ Images of x-rays or cardiology (contact film library at MedicalImagingFilmLibrary@overlakehospital.org)
☐ Pertinent record (ED notes, encounter notes, imaging, lab, cardiac reports, pathology, surgical info)	☐ Immunization records
☐ Clinic records (include name of clinic and/or provider)	☐ Billing records
☐ Emergency department records	☐ Substance Use Disorder (SUD) Records (Protected under 42 CFR Part 2)
☐ Laboratory results	☐ Psychotherapy notes
☐ Reports of imaging (x-ray) or cardiology	☐ Other

3. Dates of Service for Records to Be Disclosed:

☐ All Dates OR ☐ From: _____ (Start Date) To: _____ (End Date)

4. Recipient Information:

Recipient: _____
Address: _____
State, Zip: _____
Phone: _____ Fax: _____

5. Format for Record Delivery

- ☐ Upload the information to MyChart secure portal (must have a current MyChart account) (No Fee) _
- ☐ Mail paper copy to the address listed above. (Fees may apply)
- ☐ Fax paper copy to the provider fax number listed above. (No Fee)
- ☐ Copy the information to CD and mail to the address listed above. (Fees may apply)
- ☐ Email the information via secure email to my email address listed above. (Fees may apply)
- ☐ Email the requested diagnostic images—such as X-rays, ultrasounds, or other imaging—
through PowerShare to my email address listed above (No Fee).
- ☐ Other _____

6. Purpose of Disclosure

- ☐ Treatment or medical care
- ☐ Insurance purposes or claims processing
- ☐ Legal purposes or litigation
- ☐ Employment requirements or verification
- ☐ School or educational requirements
- ☐ For personal records
- ☐ Other _____

7. Other Important Information

I authorize the release of medical records as described above. Once my records are released, they may no longer be protected by federal or state privacy laws and may be subject to re-disclosure by the recipient. Information (e.g., substance use disclosure, mental health, etc.) used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law (42 CFR Part 2).

This authorization expires one (1) year after I sign it, unless I specify an expiration date or event here: _____

I further understand that this authorization may be revoked by me in writing at any time by contacting the HIM department, except to the extent that actions have already been taken in reliance on this authorization.

8. Signature and Consent

Signature: _____ Date: _____
(If signed by a personal representative of the patient, please complete the below)

Personal Representative's Name: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Executor of Estate*

*Please provide a copy of the legal documentation.

This authorization form can be submitted to the HIM department by mail or by fax:

Address: 1035 116th Ave NE, Bellevue, WA 98004 / Phone: 425-688-5643 / Fax: 425-467-3343

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PLACE PATIENT LABEL HERE