THE POLYCLINIC

The Polyclinic File Room for
Diagnostic Imaging Center and Breast Imaging Center
1145 Broadway, Seattle WA 98122

Please fax this completed form to: 206.860.4539
If you have questions regarding your request, please call 206.860.5496, option 3.

Patient Authorization to Disclose, Release and/or Obtain Protected Health Information

PATIENT NAME: ____________________________________ DOB: __________MRN:__________________________

PURPOSE OR NEED FOR DISCLOSURE: Please Select One

☐Attorney ☐Insurance ☐ Provider ☐Personal ☐Other (specify):___________

INFORMATION TO BE RELEASED FROM:

Name of Facility/Provider: ____

Address: ____City:_____________State:_______Zip______________

INFORMATION TO BE RELEASED To:

Name of Facility/Provider: ____

Address: ____City:_____________State:_______Zip_____________

Please select the Imaging Records to be disclosed:

☐ MRI (Magnetic Resonance Imaging) ☐CT (CAT Scan) ☐NM (Nuclear Medicine)

☐US (Ultrasound) ☐XRAY ☐Mammography ☐Breast Ultrasound ☐Breast MRI ☐Pathology Reports

☐ Include Mammography/Breast US Reports ☐ Include Imaging Reports

PATIENT AUTHORIZATION

I understand that my medical records may contain information regarding the diagnosis of treatment of HIV/AIDS, sexually transmitted disease, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (PLEASE INITIAL)

____Drug/Alcohol abuse/treatment & diagnoses ____Sexually Transmitted Disease

____HIV/AIDS diagnosis/treatment/testing ____Mental illness or psychiatric diagnosis/treatment

MY RIGHTS

I understand I do not have to sign this authorization in order to obtain health care benefits (treatments, payments or enrollment) I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Print Patient Name: ____ Relationship: _________________

Signature: ____ Date: ________________________
(Patient, Guardian, or Authorized Representative)

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED