Authorization to Disclose (Release) Personal Health Information (PHI)

Section 1: PHI Request Category

- ☐ **Donor**
  - ☐ Note: blood type can be requested by calling 800-398-7888 or through our website at http://www.bloodworksnw.org/programs/donor_card.htm
- ☐ **Patient** (please select your primary service area from the list below)
  - ☐ Hemophilia Clinic
  - ☐ Patient Services
  - ☐ Research Services
  - ☐ Therapeutic Phlebotomy
  - ☐ Hemostasis
  - ☐ Transfusion Services
  - ☐ Other: _____
- ☐ **Former Employee** – please contact Bloodworks' Safety Officer at 206-689-6608

Section 2: Patient/Donor Demographics

Print Name of Patient/ Donor: _____

Birthdate _____

Street Address _____

City/State/Zip _____

Daytime Phone # _____

Fax #: _____

Email Address _____

Section 3: Information to be released to:

- ☐ Donor/Patient listed in Section 2
- ☐ Health Care Provider or Other Third Party: _____
  Street Address _____
  City/State/Zip _____
  Phone: _____ Fax # _____
  Email Address: _____
  ☐ Send copy of released PHI to donor/patient listed in Section 2 via ☐ U.S. Mail ☐ Fax ☐Encrypted email

Section 4: What kind of information do you want released?

Information will be sent from most recent two years unless date range is specified below.

Date range: _____ to _____

Donors ☐ Test Results ☐ Blood Pressure Readings ☐ Pulse Readings ☐ Hematocrit Levels ☐ Donation Dates ☐ Other: _____

Patients: ☐ All medical records ☐ Research Records – *please specify the name of trial, trial dates, and physician (if known)* _____

☐ Billing Records ☐ Other (please specify) _____

Section 5: Donor/Patient authorization

Information released may include information regarding the testing or diagnosis of HIV/AIDS or sexually transmitted diseases. I hereby give my specific authorization for this information to be released.

I authorize Bloodworks Northwest to release information regarding my donor or patient history diagnosis or treatment to the organization or person stipulated above.

I have the right to revoke (take back) this authorization at any time in writing to the Bloodworks Northwest Compliance Officer. Exceptions and the Compliance Officer address can be found in the Bloodworks Northwest Privacy Notice. Signed authorizations shall expire 90 days from the date of signing.

Once disclosed, PHI may be subject to redisclosure by the recipient and may no longer be protected under health information privacy laws.

Signature: _____

Patient or Donor, Guardian*, or Authorized Representative*

*Documentation may be required to prove authority to sign on behalf of the patient

Minor Signature _____

(Signatures of minors aged 13-17 is required for certain information, see Section 5 instructions on page two).

This authorization expires 90 days from the date signed OR on the date indicated below:

_____

Section 6: Transmittal Method

Please send records via: ☐ U.S. Mail ☐ Fax ☐ Encrypted email

Section 7: Submitting this Form

You can submit this signed form via the following ways

☐ U.S. Mail to PHI/Records Department, Bloodworks Northwest, 921 Terry Avenue, Seattle, WA 98104

☐ Fax to 1-866-290-3412

☐ Email to PHI@Bloodworksnw.org

Have questions? Please email PHI@Bloodworksnw.org or call 206-689-6527.

Instructions for Requesting Release of Personal Health Information (PHI)

Please follow these instructions to expedite processing of your request. Thank you.

Section 1: PHI Request Category

Please indicate if you are a **donor** or a **patient**.

If you are a **patient**, please indicate which service areas provided care to you.

If you are a **former employee** looking for vaccination or other health records, please contact our Safety Officer at 206-689-6608.

Section 2: Patient/Donor Demographics

Please enter your demographic and contact information. Please include your daytime phone or email address so we can follow up with you if we have questions.

Section 3: Information to be released to:

Please use this section to indicate where we should send your records. If we are sending information to a third party, please check whether you would also like a copy of the information.

Section 4: What kind of information do you want released?

Please check the type of information you are seeking. If the information is not listed, please specify in the space provided.

If you are requesting information regarding a **research trial**, please list the name of the trial, the dates that you participated, and the name of the physician.

Section 5: Donor/Patient authorization

Please read and sign the authorization. Sign and indicate the date signed for patients aged 18 and older. **Minors between the ages of 13 and 17** must authorize the release of certain information concerning the minor including HIV/AIDS and sexually transmitted diseases.

The authorization will expire 90 days from the date signed unless you indicate another date.

Section 6: Transmittal Method

Please indicate how you wish us to transmit the information to you and/or the third party.

Charges

There is no charge for copying your medical records if you have the copies sent directly to you, health care facility or provider for continuing or transfer of care. If you are requesting copies of medical records for an attorney or an insurance provider, fees may be applied for portable electronic media supplied by Bloodworks Northwest. In addition, postage and sales tax may be charged. You may be invoiced or required to pay applicable fees prior to obtaining the copies. Payment is otherwise due upon receipt of your copies. Please allow up to 15 days for processing your request.

Have questions? Please email PHI@Bloodworksnw.org or call 206-689-6527.