Optum

Optum Care Washington, PLLC

Authorization to release medical records

Patient information:

Name (Print) **please include maiden or other name if applicable.* DOB SSN

_____ _____ _____

Information to be released from:

Name of facility or provider

_____

Address

_____

Information to be sent to:

Name of designated recipient

_____ Fax number: _____

Address City State Zip

_____ _____ _____ _____

Release to active MyChart acct: Yes ____ No ____ Initials _____

Release through secure portal: Yes ____ No ____ Initials _____

Email Address: _____

Information to be released: (check one)

☐ The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)
☐ All medical records
☐ Specific information (please specify)

Purpose for which the disclosure is being made: (check one)

☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, 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 & diagnosis

_____ 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 (treatment, payment or enrollment). I may revoke this authorization in writing. Patient or Personal Representative can revoke this authorization upon written request.

If you revoke, it will not affect information disclosed before the receipt of the written request. 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.

Fee disclaimer: Federal and state laws permit Optum to charge a reasonable fee for copying/releasing records. State regulated fees for labor and supplies may apply. You will be notified directly regarding any fees and payment as required.

Signature: _____ Date: _____

(Patient, guardian*, or Authorized representative*)

***Note: Requests can take up to 15 business days to process. Please indicate urgency when necessary.**

This authorization will expire 90 days from the date signed. Possible copying fee required

Please fax this completed form to: 1-678-897-4264 or mail to: Optum Care Washington - Health Information Department, 3901 Hoyt Avenue, Everett, WA 98201

If you have questions regarding your request, please call: 1-888-423-1079 (please allow 48 hours for your request to be received and entered into our system before calling)

Optum Care Washington, PLLC

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities. We provide free services to help you communicate with us. This includes letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call 1-425-382-4790, TTY 711. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idioms, sin cargo, a su disposición. Llame al 1-425-382-4790, TTY 711. 請注意：如果您說中文 (Chinese)， 我們免費為您 提供語言協助服務。請致電： 1-425-382-4790, TTY 711。