Family Care Network
We Take Care

INCOMING REQUEST
FOR PROTECTED HEALTH INFORMATION (PHI)

AUTHORIZES THE FACILITY/PERSON YOU LIST BELOW TO RELEASE INFORMATION TO OUR OFFICE

Patient Name _____ Date of Birth _____ Previous Name _____

AUTHORIZATION

I authorize: Facility/clinic: _____ Provider/person: _____
Address: _____
Phone: _____ Fax: _____

To disclose health care information to:

❑ **Bellingham Bay Family Medicine**
722 N State St
Bellingham, WA 98225
p 360.752.2865 f 360.647.8093

❑ **Birch Bay Family Medicine**
8097 Harborview Rd
Blaine, WA 98230
p 360.371.5855 f 360.371.5857

❑ **Chuckanut Family Medicine**
1310 10th St Ste 104
Bellingham, WA 98225
p 360.594.0592 f 360.526.2165

❑ **Family Health Associates**
3500 Orchard Pl
Bellingham, WA 98225
p 360.671.3900 f 360.647.0882

❑ **Ferndale Family Medical Center**
5580 Nordic Way
Ferndale, WA 98248
p 360.384.1511 f 360.384.5758

❑ **Island Family Physicians**
2511 M Ave Ste A
Anacortes, WA 98221
p 360.293.9813 f 360.299.8605

❑ **Lynden Family Medicine**
1610 Grover St Ste D-1
Lynden, WA 98264
p 360.354.1333 f 360.354.5399

❑ **Mount Vernon Family Health**
916 S 3rd St
Mt Vernon, WA 98273
p 360.336.5658 f 360.336.5655

❑ **North Cascade Family Physicians**
2116 E Section St
Mt Vernon, WA 98274
p 360.428.1700 f 360.848.4350

❑ **North Sound Family Medicine**
2075 Barkley Blvd Ste 105
Bellingham, WA 98226
p 360.671.3345 f 360.650.1354

❑ **Sports Medicine**
3130 Squalicum Pkwy
Bellingham, WA 98225
p 360.756.0382 f 360.756.5184

❑ **Squalicum Family Medicine**
3015 Squalicum Pkwy Ste 120
Bellingham, WA 98225
p 360.676.9336 f 360.676.2567

❑ **Whatcom Family Medicine**
3015 Squalicum Pkwy Ste 160
Bellingham, WA 98225
p 360.671.4402 f 360.671.9463

You may use or disclose the following health care information (check all that apply):

❑ All health care information in my medical record *(see next section to release protected information)*

❑ Health care information in my medical record relating only to the following treatment or condition:
- ❑ Last year of lab report(s)
- ❑ Last pap report
- ❑ Last mammogram report
- ❑ Last DEXA report
- ❑ Last colon cancer screening report
- ❑ Immunizations
- ❑ Problem list
- ❑ Medication list
- ❑ Other: _____

❑ Health care information in my medical record only for the date(s) of: _____

❑ Laboratory/X-Rays/Imaging: _____ ❑ Billing/Payment: _____

You may use or disclose information regarding testing, diagnosis and treatment for (check all that apply):

- ❑ HIV (AIDS virus)
- ❑ Sexually transmitted diseases
- ❑ Mental health or illness
- ❑ Drug and/or alcohol use
- ❑ Reproductive health care – checking this box is needed to release information if the patient is under age 18 (per Washington State law).

-Continued on back-

Patient Name _____ Date of Birth _____

Minors – a minor patient's signature is required in order to disclose information related to reproductive care *(at any age)*, sexually transmitted diseases *(age 14 and older)*, HIV/AIDS *(age 14 and older)*, drug and/or alcohol abuse *(age 13 and older)*, and mental health or illness *(age 13 and older)*.

AUTHORIZATION

Reason(s) for this authorization (check all that apply):

- ❑ At my request
- ❑ Transfer of care
- ❑ Other (specify):_____
- ❑ For marketing purposes

This authorization ends:

- ❑ On a specific date: _____
- ❑ When the following event occurs: _____
- ❑ 90 days from the date signed
- ❑ When I cancel this authorization

My Rights

A. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
   - to receive research-related treatment in connection with research studies **or**
   - to receive health care when the purpose is to create health care information for a third party.

B. I may cancel this authorization in writing at any time. If I do, it will not affect any actions taken by Family Care Network in reliance on this authorization before it receives my written cancellation. I may not be able to cancel this authorization if its purpose was to obtain insurance. To cancel this authorization:
   - complete the box below
   - write a letter to Family Care Network

Protection after Disclosure

Information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

_____

Patient or legally authorized individual signature Date Time

_____

Printed name (if signed on behalf of the patient) Relationship *(parent, legal guardian, personal representative)*

_____

Minor patient's signature, if applicable Date Time

❑ CANCEL THIS AUTHORIZATION

Patient signature: _____ **Date:** _____