AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

CSC
Hanford Occupational Health Services

I, _____ _____
(Name of Individual) (Social Security Number)

_____ _____
(Daytime Phone) (Date of Birth)

authorize CSC Hanford Occupational Health Services, P.O. Box 150 G3-70, Richland, WA 99352

MARK ITEMS **NAME AND ADDRESS OF INSTITUTION**

☐ to disclose to _____

☐ to exchange with _____

☐ to receive from _____

INFORMATION TO BE DISCLOSED **INFORMATION SENT:** _____

Medical

☐ X-Ray results
☐ Laboratory results
☐ ECG results
☐ PFT results
☐ HIV results
☐ Exam results: _____ *(Specify Date)*

Behavioral Health

☐ Intake
☐ Progress Notes
☐ Psychological testing
☐ Urine drug screen
☐ Consultation
☐ Psychological Reports

☐ Other: _____ *(Please specify)*

PURPOSE

☐ Status report ☐ Medical referral ☐ Private use
☐ Treatment monitoring ☐ Court/litigation-related ☐ Counseling/therapeutic value
☐ Other: _____ *(Please specify)*

Notification to patient/client: "Some or all of the responsive documents being provided in fulfilling this request include Protected Health Information/Personally Identifiable Information (PHI/PII) including but not limited to name, social security number, and date of birth."

This authorization will expire on: _____ (date) or _____ (an event that relates to the patient)
If the disclosure of PHI/PII is to a financial institution or an employer for purposes other than payment, this release is valid for and expires in 90 day's from date of signature.

I understand that information about my case is confidential and may be protected by federal and state law. I understand that once disclosed, this information may be re-disclosed to others and that the information might not be protected under state and federal privacy regulations once released. I may revoke this authorization at any time by writing to the above-named provider, but I understand that the cancellation will not affect any use of information that was already released before the cancellation. I understand that the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that I have the right to inspect or request a copy of the health information disclosed under this authorization. I understand what this authorization means and I am satisfied with any explanations I may have requested or received. I certify that I have been provided a copy of this signed authorization.

This disclosure authorization is specifically intended to include any references to diagnosis, testing, and/or treatment for communicable disease, including sexually transmitted disease (e.g., HIV/AIDS/AIDS-related illnesses), mental health services governed by RCW 70.24, or drug and/or alcohol services governed by 42CFR Part 2.

This information has been disclosed to you from records protected by federal confidentiality rules (Title 5, U.S.C., Sec 552a, 42 CFR §§ 160 & 164, and 42 CFR Part 2). Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it concerns.

_____ _____
Patient/Client Signature Date
(If Patient/Client is 13 years of age or older, he/she must sign consent form.)

_____ _____
Parent/Legal Guardian/Responsible Other Relationship

PRIVACY ACT PROTECTED