ISLAND HOSPITAL

One Patient/One Facility per Request For internal purposes only: M#_____ IH#_____

***Patient Name:** _____ ***Date of Birth:** _____

***INFORMATION TO BE RELEASED FROM:** _____
Name of Department/Clinic

***INFORMATION TO BE RELEASED TO:** _____
Name of Parent or Legal Guardian

Minors (defined by law as a person under the age of 18 years unless otherwise noted for specific conditions):
A minor patient's signature is required in order to release the following information (per Washington State Law):

1. Conditions relating to birth control, abortion or prenatal services (at any age)
2. Sexually transmitted diseases, including HIV/AIDS (if age 14 or older)
3. Alcohol and/or drug abuse and mental health conditions (if age 13 and older)

***Patient Authorization:**
This authorization specifically allows the release of the following information (**this information will NOT be released unless the appropriate line is initialed.)**

_____ Any record of treatment for birth control, abortion or prenatal services

_____ Any record of treatment for sexually transmitted diseases, including HIV/AIDS

_____ Any record of outpatient mental health treatment

_____ Any record of outpatient drug and/or alcohol treatment

This authorization is effective for 1 year from date of execution; however I may revoke it at any time by providing written notice to Island Hospital.

Patient 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 at any time except to the extent already relied upon by sending a request in writing to Island Hospital Privacy Officer, 1211 24th Street, Anacortes, WA. 98221.

I understand I have the following rights to:

- Inspect or receive a copy of my protected health information
- Receive a copy of this signed form
- Refuse to sign this form for authorization to disclose or release my protected health information

I understand that once Island Hospital discloses health information, the person that receives it may re-disclose it, at which time it may no longer be protected under Privacy Laws.

I understand that the confidentiality of these records will be protected by Island Hospital and its clinics under the authority of Federal (HIPAA, 45 CFR parts 160 and 164) and/or State of Washington laws. I also understand that some of my records may be protected under Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in these regulations.

By signing this page, I acknowledge that I have read and agree to the terms on this page.

***Signature:** _____ ***Date:** _____
Minor Patient's Name

***If signed by person other than patient, provide reason, relationship to patient, or description of authority**: _____

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