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How to Complete Your Washington HIPAA Authorization

Authorization for Release of Protected Health Information (45 C.F.R. 164.508)

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. Federal privacy law (HIPAA) limits who doctors, hospitals, and insurers can talk to about you. This authorization lets the people you name receive your health information so they can help you.

1. **Who and what (Page 1)**
   Name the people who may receive your information and choose what may be released. Initial any specially protected records you want included.
2. **Sign before a notary (Page 2)**
   Hospitals and insurers are more likely to accept a notarized authorization without question. Bring a current, government-issued photo ID.

After It's Signed

- Give copies to the people you named and to your doctors and health plans.
- This form works best with a Washington Durable Power of Attorney for Health Care. We have a free form.

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Washington-Commissioned Notaries

SCAN TO BOOK

Questions about this document? Talk to an attorney. Gavrilov & Brooks Law Firm has attorneys licensed in multiple states. Phone and video consultations are available, wherever you are. **(916) 504-0529** · **www.gavrilovlaw.com**

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YOUR FORM BEGINS ON THE NEXT PAGE

HIPAA AUTHORIZATION

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1. PATIENT

Full legal name

Date of birth

Address

Telephone

2. WHO MAY RELEASE INFORMATION. Every physician, hospital, clinic, laboratory, pharmacy, therapist, health plan, insurer, and other covered entity that has provided treatment, services, or payment to me.

3. WHO MAY RECEIVE INFORMATION

Name	Relationship	Telephone
Name	Relationship	Telephone
Name	Relationship	Telephone

4. INFORMATION TO BE RELEASED (check one)

All of my health information, including records, test results, diagnoses, treatment, billing, and payment records.

Only the following:

Unless I initial below, this authorization does not include psychotherapy notes or the following specially protected records. I separately authorize release of (initial each):

☐ Mental health records (other than psychotherapy notes)

☐ HIV/AIDS and other communicable disease information

☐ Substance use disorder treatment records

☐ Genetic testing information

Patient's initials: _____

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5. PURPOSE. At my request, to allow the persons named to discuss my care with my providers and assist with my health care and insurance matters.

6. EXPIRATION (check one)

Two years after my death.

On the following date or event:

Date or event

7. MY RIGHTS. I may revoke this authorization in writing at any time, except for action already taken in reliance on it. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing it. Information disclosed may be redisclosed by the recipient and may no longer be protected by federal privacy rules. A copy is as valid as the original. My agents under any medical durable power of attorney are to be treated as my personal representatives.

Date

X

Signature of patient (or personal representative)

Printed name

NOTARY ACKNOWLEDGMENT

STATE OF WASHINGTON)
) ss.
**COUNTY OF) **

This record was acknowledged before me on

(date)

by (name of signer)

X

Notary Public

(Notary seal)

Notary's printed name

Title (Notary Public, State of Washington)

My commission expires

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