

Patient Authorization to Disclose, Release, and/or Obtain Protected Health Information

Recent medical records are available via MyChart for immediate download without filling out this form. See page 3 for more information.

1. Patient Information *Death Harborview Surgery Trauma Center March 11, 2025 4:35pm*

Name - Last, First, MI <i>Hoffman, Jeanne Leonie</i>	Former Name(s)/Alias		
Street Address <i>321 High School Road NE D3-292 Bainbridge Is WA</i>	City <i>98110</i>	State	Zip
Email Address <i>Jeanhoffman and/or Louisalloin@USA.com</i>	Birthdate <i>1/6/1925</i>	Phone <i>206-780-6885</i>	

2. Purpose of Request

<input type="checkbox"/> Attorney	<input type="checkbox"/> Insurance	<input type="checkbox"/> PFMLA
<input type="checkbox"/> Provider	<input type="checkbox"/> Personal	<input checked="" type="checkbox"/> Other (specify) <i>Death Executive of State</i>

3. Facilities to Release Records

<input checked="" type="checkbox"/> Harborview Medical Center & Clinics	<input checked="" type="checkbox"/> UW Medical Center & Clinics—Northwest	<input checked="" type="checkbox"/> UW Medicine Primary Care
<input type="checkbox"/> Valley Medical Center (VMC) & Clinics	<input checked="" type="checkbox"/> UW Medical Center & Clinics—Montlake	<input checked="" type="checkbox"/> UW Physicians

Provider/Clinic (Please send this form directly to non-UW Providers): _____
Address: _____ Phone: _____ Fax: _____

4. Recipient of Records (e.g., Insurance Company, Attorney, Physician, Patient)

Name <i>Louis Alloin</i>	Attention To	Phone <i>206-780-6885</i>	Fax	Email <i>louisalloin@usa.com</i>
Street Address <i>321 High School Road NE D3-292 Bainbridge Is WA</i>	City	State	Zip <i>98110</i>	

5. Records to be Disclosed: Date Range: *1980* to *Current* OR Most Recent 2 Years (default if no dates listed)

<input checked="" type="checkbox"/> Medical Records	<input checked="" type="checkbox"/> Billing Records	<input checked="" type="checkbox"/> Immunizations	<input checked="" type="checkbox"/> Radiology Images
<input checked="" type="checkbox"/> Clinic Notes	<input checked="" type="checkbox"/> Labs and Pathology	<input checked="" type="checkbox"/> Procedures	<input checked="" type="checkbox"/> Radiology Reports
<input checked="" type="checkbox"/> Other (please specify): <i>Autopsy & Medical Examiner</i>			
<input type="checkbox"/> AND/OR: I authorize VERBAL COMMUNICATION ONLY about my medical history and care.			

This authorization permits UW Medicine to release information related to sexually transmitted diseases, HIV/AIDS/AIDS-related illnesses, behavioral or mental health services, and treatment for alcohol and drug abuse.

***Optional* Please check below if you would like medical records from these units released. Medical records directly related to your care from these units are excluded by default, but some information may be released even if you do not make a selection if referenced elsewhere in your chart. This section does not apply to billing records.**

<input type="checkbox"/> Sexual Assault Nurse Examination Records	<input checked="" type="checkbox"/> Harborview Abuse and Trauma Center Records
<input checked="" type="checkbox"/> Living Donor Records	<input type="checkbox"/> Hall Health Mental Health Records

6. Format for Records: If verbal communication only, skip this item.

NOTE: Radiology Images are on CD, and require DICOM viewer.

<input checked="" type="checkbox"/> CD/DVD (required PDF viewer)	<input checked="" type="checkbox"/> Paper	<input checked="" type="checkbox"/> MyChart	<input checked="" type="checkbox"/> USB/Thumb Drive	<input type="checkbox"/> Email (see page 3)
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7. This authorization is in effect until _____ (date) OR when the following event occurs: _____

(If no date/event is provided, the authorization will be valid for three years from the signature date. Authorizations to disclose your information to an employer or financial institution may only be effective for one year.)

By signing the above page, I acknowledge that I have read and agree to the terms on both sides of this form.

Signature (Patient or Person Authorized to Give Authorization) <i>Louis Charles Hoffman Alloin POA</i>	Date <i>April 25, 2025</i>
If Signed by Person Other Than Patient, Provide Printed Name, Reason, Relationship to Patient, Description of Their Authority <i>Louis Charles Hoffman Alloin, Death Exec, Son, Caregiver, POA Guardian/et</i>	

PLACE PATIENT LABEL HERE

UW Medicine

Harborview Medical Center – University of Washington Medical Center
UW Medicine Primary Care – Valley Medical Center – UW Physicians

AUTH TO DISCLOSE/OBTAIN PHI

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U0626

WHITE – MEDICAL RECORD
CANARY – PATIENT

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Minors: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care; (2) sexually transmitted diseases (if age 14 and older); (3) alcohol and/or drug abuse and mental health conditions (if age 13 and older).

Patient Rights: I understand I do not have to sign this authorization in order to obtain healthcare 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 UW Medicine Compliance Office Box 358049, Seattle, WA 98195. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, it may no longer be protected under privacy laws and it may be re-disclosed.

I understand I have the following rights to:

- Inspect or to 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 also understand UW Medicine will not base treatment or payment decisions on receipt of this signed authorization, except in these cases: (1) UW Medicine may condition research-related treatment on my signing or my providing an authorization for the use or disclosure of my information for such research or (2) UW Medicine may condition the provision of healthcare that is just for the purpose of creating protected health information for disclosure to a third party on my signing or my providing an authorization for the disclosure of the health information to such third party. An example of this is when a non-UW employer contracts with UW Medicine to conduct TB testing for purposes of employee health screening.

This authorization form can be sent to us by postal mail, email, or fax.

Harborview Medical Center and Clinics

UW Medical Center and Clinics—Montlake

UW Medical Center and Clinics—Northwest

UW Medicine Primary Care

UW Physicians

Hall Health Center

Mail: Enterprise Records and Health Information

Box 354914

1959 N.E. Pacific St.

Seattle, WA 98195

Fax: (206) 744-9997

Phone: (206) 744-9000

Email: uwmedroi@uw.edu

Valley Medical Center and Clinics

Mail: Release of Information

400 S 43rd Street

P.O. Box 50010

Renton, WA 98058

Fax: (425) 690-9407

Phone: (425) 690-3406

Email: RecordsRequest@valleymed.org

Request for Billing Records (non-VMC)

Mail: Patient Accounts & Support Services

7527 63rd Ave. NE—Building 5C

Seattle, WA 98115

Phone: (206) 520-0400 or (800) 520-0400

Email: passroi@uw.edu

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