PUGET SOUND BLOOD CENTER AND PROGRAM
921 Terry Avenue, Seattle, WA 98104-1256
MAIN # (206)292-6500 FAX (206)292-8030

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT/DONOR INFORMATION:

FULL NAME		BIRTHDATE	SS#
ADDRESS	CITY	STATE	ZIP
PERSON RESPONSIBLE - PARENT/LEGAL GUARDIAN			

INFORMATION TO BE DISCLOSED:

TO WHOM THE INFORMATION SHALL BE DISCLOSED:

NAME	INSTITUTION (If Applicable)		
ADDRESS	CITY	STATE	ZIP

PURPOSE OF THE REQUEST:

If requested by the patient/donor, “At the request of the patient/donor” is sufficient.

SEXUALLY TRANSMITTED DISEASE INFORMATION: (Includes HIV/AIDS)

I understand that my records may contain information regarding sexually transmitted disease or HIV/AIDS status and I further authorize the release of such information. INITIALS____

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the Puget Sound Blood Center to release information regarding my donor or patient history, diagnosis or treatment to the person stipulated above.

SIGNATURE TO RELEASE INFORMATION:

PATIENT/DONOR or PARENT/LEGAL GUARDIAN	DATE
WITNESS/NOTARY (if necessary)	DATE

REVOCATION/EXPIRATION: The patient/donor has the right to revoke (take back) this authorization at any time if done so in writing to the PSBC Compliance Officer. Exceptions and the Compliance Officer address can be found in the PSBC Privacy Notice. Signed authorizations shall expire in 90 days from the date of signing.

COPIES: The patient/donor will be provided with a copy of this signed authorization.

NOTE: Forward all completed authorizations to PSBC Records Management.