AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

This authorization expires 6 Months from date signed

PATIENT INFORMATION:

_____
Print name of patient (include all names patient may be known by)

_____ _____ _____
Birthdate Social Security Number Address/phone

INFORMATION TO BE RELEASED FROM: _____
Name of designated facility or provider

_____
Address

_____
City/State/Zip Phone/Fax

INFORMATION TO BE RELEASED TO:
(Recipient) _____
Name of designated recipient

_____
Address

_____
City/State/Zip Phone

DISCLOSURE PURPOSE: Continuity of Care _____ Insurance _____ Attorney _____ Personal _____ (fee may apply)

****THE PURPOSE OF THIS FORM IS TO KEEP RELEASE OF INFORMATION FORM ON FILE ONLY** _____

DATE(S) OF RECORDS REQUESTED: _____
INFORMATION TO BE RELEASED (INITIAL THE SPACES):

_____ Emergency and Urgent Care Records _____ Laboratory/Pathology Reports _____ Billing Statements

_____ Dictated Reports (Discharge, History & Physical…) _____ Diagnostic Imaging Paper Report and/or _____CD (x-ray, CT, MRI, US)

_____ Other (specify) _____

____ Please send the entire medical record (all information) to the above named recipient. The requester understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

*I understand that my records may contain information regarding the diagnosis or treatment of HIV/Aids, sexually transmitted diseases, drug and/or alcohol use, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released (**MUST BE INITIALED** to be included in other documents).

_____ *Sexually Transmitted Diseases including HIV/AIDS
_____ *Chemical dependency (includes alcohol/drug treatment)
_____ *Psychiatric, mental or behavioral health information
_____ *Reproductive Health (including abortion)
_____ *Genetic information (OR)

Federal regulations require a description of how much and what kind of information is to be disclosed.

Describe: _____

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I understand these records can not be disclosed without written consent, except as provided for under Federal and State law. This authorization may be revoked in writing at any time, except to the extent that disclosure has already taken place in reliance to the authorization. To view the process for revoking this authorization, please read the Privacy Notice to Patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under the Privacy laws. The District is not responsible for my Medical Records while they are in my custody. **There may be a per page fee involved in duplicating records. A statement of cost can be obtained from the H.I.M department. Photo identification is required when picking up medical records.**

_____ _____
Date **Signature** of Patient OR Person Authorized by Law & Relationship to Patient (parent, legal guardian*, Holder of Power of Attorney*)
(*attach legal documentation if you are the legal guardian or Holder of Power of Attorney)

Please return completed request to:

Ferry County Public Hospital
ATTN: Medical Records
36 Klondike Road
Republic, WA 99166
Ph: (509) 775-3333
Fax: (509) 775-3117

or

Republic Medical Clinic
ATTN: Medical Records
10 Ros Circle
Republic, WA 99166
Ph: (509) 775-3153
Fax: (509) 775-8929