# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**Central Washington Hospital & Clinics**
**Wenatchee Valley Hospital & Clinics**

## PATIENT INFORMATION

Patient Name: _____ Date of Birth: / /
*Last* *First* *M.I.*

Address: _____ Phone: ( )
*City* *State* *Zip Code*

## Records to be released from:

☐ Central Washington Hospital & Clinics ☐ Other: _____
☐ Wenatchee Valley Hospital & Clinics

## Records to be disclosed to: (eg. Insurance Company, Attorney, Physician, Patient)

Name of Person/Entity (***Who*** *may have the information?):* Phone: _____
Fax: _____
Address of Person/Entity (***Where*** *do you want the information sent?)* Email: _____

*Street* *City* *State* *Zip Code*

## PURPOSE OF RELEASE

☐ Continuing/Transferring Care ☐ Attorney/Legal ☐ Insurance Company ☐ Other
☐ Personal Use ☐ Billing/Claims ☐ School/Employment

## DELIVERY METHOD

I authorize my records to be delivered in the following method:

☐ US Mail- Paper Only ☐ Fax ☐ View/Access of Personal Health Information
☐ Email ☐ MyChart

**X-Ray Imaging Only:**
☐ Pick up - CWH Radiology
☐ Pick up - WVH Radiology
☐ Pick up - Moses Lake Radiology

## INFORMATION TO BE DISCLOSED

☐ Office Visit ☐ Immunizations ☐ Discharge Summary ☐ X-Ray Imaging
☐ Labs ☐ Procedure Report ☐ History & Physical Report ☐ Imaging Report
☐ Medications ☐ Emergency Report ☐ Billing Records ☐ Other: _____

**Specific Dates/Years:**

## SENSITIVE HEALTH INFORMATION

If your health information contains any of the following, please check all categories that apply.
***By checking a box below, you are authorizing the release of sensitive information:***

☐ Alcohol/Drug or Substance Abuse ☐ Behavioral Health / Psychotherapy Records ☐ Sexually Transmitted Infections ☐ HIV / AIDS Testing / Results ☐ Genetic Records

## AUTHORIZATION

I understand that: Requests for copies of medical records subject to reproduction fees in accordance with federal/state regulations. • I have the right to revoke this authorization at any time. Revocation must be made in writing and mailed to the Health Information Management Department at the following address: Confluence Health, P.O. Box 3510, Wenatchee, WA 98807. Revocation will not apply to information that has already been disclosed in response to this authorization. •Unless otherwise revoked, this authorization will expire in 90 days from the date signed. •Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization. •Any disclosure of information carries with it the potential for unauthorized disclosure, and the information may not be protected by Federal confidentiality rules.

Printed Name of Patient/Legal Representative: Relationship to Patient: _____

Signature of Patient/Legal Representative: Date: Time: _____

Signature of Minor (Age 13-17) if Requesting Sensitive Information: