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 ☐ Fax ☐ Pick-up – CWH Patient Services ☐ Pick-up - Moses Lake Clinic Patient Services
☐ Email ☐ MyChart ☐ Pick up – WVC Information Desk ☐ View/Access of Personal Health Information

DISCLOSURE FORMAT

I request that my records be produced in the following format *(To be used when US Mail or Pick-up is selected as a delivery method)*:

☐ Paper **OR** ☐ Digital file on a CD

INFORMATION TO BE DISCLOSED

☐ Office Visit ☐ Immunizations ☐ Discharge Summary ☐ History & Physical Report
☐ Labs ☐ Medications ☐ Surgical Report ☐ Radiology Report
☐ X-Rays ☐ 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: