



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION

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

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

Records to be released from:

Confluence Health Other: _____

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 **Imaging** is only available by secure email. Please make sure your email is listed above and imaging is selected below.
 Email MyChart

INFORMATION TO BE DISCLOSED

<input type="checkbox"/> Office Visit	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> X-Ray Imaging	Specific Dates/Years:
<input type="checkbox"/> Labs	<input type="checkbox"/> Procedure Report	<input type="checkbox"/> History & Physical Report	<input type="checkbox"/> Imaging Report	
<input type="checkbox"/> Medications	<input type="checkbox"/> Emergency Report	<input type="checkbox"/> Billing Records	<input type="checkbox"/> Other: _____	

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

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 or by email at HIM@ConfluenceHealth.org. 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: _____