Wenatchee Valley Hospital & Clinics
Central Washington Hospital & Clinics

AUTHORIZATION FOR RELEASE OR PATIENT ACCESS TO PROTECTED HEALTH INFORMATION (PHI)

1. Patient Information

Name:________________________ Date of Birth: ________________

Address:________________________ Phone: ________________

City/State:________________________ MR#:________________

Authorization is hereby granted for release of information

2. RELEASE FROM:

Name:________________________

Address:________________________

City/State:________________________

Phone: ________________________

Facility Fax: ________________________

RELEASE TO:

Name:________________________

Address:________________________

City/State:________________________

Phone: ________________________

Facility Fax: ________________________
(Facility only. We do not fax directly to patient's personal fax numbers.)

3. Purpose for requesting information: ☐Personal ☐Continuation of Care ☐Legal ☐Insurance ☐Other ________________
Covering the period of healthcare from: Specific Date(s):____________ to____________ OR ☐Present

4. OFFICE VISIT: ☐ Last 2 years (transfer of care) ☐Last 3 years ☐Last 5 years ☐All medical records ☐Immunization
☐Medical records relating to the following treatment/condition: ________________
☐Diagnostic Images & Reports (paper / CD) ☐Bills ☐Other: ________________

5. HOSPITAL SERVICES: I authorize the following PHI to be released from my medical record(s): ☐Emergency Room Record ☐Laboratory Report(s) ☐Radiology Report(s) ☐Immunization Record ☐Complete Medical Record (all pages) ☐Diagnostic Images & Reports (paper / CD) ☐Itemized Billing Records ☐Abstract/Summary (includes Discharge Summary, History and Physical, Operative Report(s), Consultations & Test Results
☐Other: ________________

6. You may release information regarding testing, diagnosis, and treatment for (check all that apply): I understand that the information in my health records may include information relating to mental health services, and treatment of alcohol or drug use. **State and federal law protects the following information. If this information applies to you, please indicate if you would like this information released/obtained.** •Alcohol, Drug, or Substance Abuse Records: ☐Yes ☐No • HIV Testing & Results: ☐Yes ☐No •Sexually Transmitted Disease: ☐Yes ☐No •Mental Health/Psychotherapy Records: ☐Yes ☐No •Genetic Records: ☐Yes ☐No

7. Delivery Options – I authorize my records to be: ☐ U.S. Mail ☐ Fax ☐ MyChart ☐ Picked up at: ☐ CWH ☐ WVH or Pick up at:__________
Disclosure Format: Paper files: ☐Yes ☐No Digital files on CD: ☐Yes ☐No

8. Patient Rights ***By signing this authorization form, 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 presented 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 redisclosure, and the information may not be protected by federal confidentiality rules.

9. ☐ View / Access of PHI

________________________ ________________
Patient or legally authorized representative signature Date

________________________ ________________
Printed Name Relationship to patient (parent, legal guardian, personal representative)

________________________ ________________
Minor signature (Signature of minor is also required if minor is age 13-17) Date

FOR OFFICE USE ONLY

☐ Power of Attorney Attach copy ☐ Healthcare Power of Attorney Attach copy ☐ Court Order Attach copy ☐ Other:________________ Total Pages Released________

____
(Please print) Person picking up records Date

☐ Drivers License
☐ Photo ID
☐ Other ID:________________
☐ Applicable Fees Paid
Release ID # ________________

____
Staff who prepared records Date

____
Signature of person picking up records Date

____
Staff who released records Date