COLUMBIA MEMORIAL HOSPITAL

2111 Exchange Street
Astoria, Oregon 97103
Tel: 503-338-7528
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RELEASE OF INFORMATION

Purpose: This form is an authorization to release protected health information.

SECTION A: Patient Information

Name: ____

Address: ____

Telephone: ______________________ Date of Birth: ______________________

SECTION B:
Protected Health Information to be Released

Date of Service OR Description of Service

- ☐ Emergency Room ______________
- ☐ Lab Reports ______________
- ☐ Imaging CD/ Reports ______________
- ☐ EKG/ EEG ______________
- ☐ History & Physical ______________
- ☐ Inpatient Progress Notes ______________
- ☐ Operative Report ______________
- ☐ Discharge Summary ______________
- ☐ Clinic Chart Notes ______________
- ☐ Physical Therapy ______________
- ☐ Other* ______________

(*specify*) ______________________

SECTION C:

☐ **Send Records To:** ☐ **Request Records From:**

____
Individual/Facility / Agency

____
Address

____
City / State / Zip

____
Tel Number

____
Fax Number

____
Email Address

SECTION D: I specifically release the following:

☐ HIV/AIDS/STD's_______ (Initials) ☐ Drug/Alcohol Diagnosis and Treatment_______ (Initials)
☐ Mental Health Diagnosis and Treatment_______ (Initials) ☐ Genetic Info_______ (Initials)

PATIENT'S SIGNATURE.

I have had the full opportunity to read and consider the contents of this authorization. I understand that by signing this form I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Patient Signature/Representative: ______________________________Date: ______________

Personal Representative's Name:______________________________________

Relationship to Patient:______________________________________

SECTION E: Purpose of this Authorization:

☐ Continuing Care ☐ Insurance ☐ Legal ☐ Other:______________________

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

HIPAA Form 3B
Revised 08-15-17

Include this authorization in the individual's medical records

FOR HOSPITAL USE

Date prepared: __________ Initial: ________

Date of release: _________ ☐ Pt. Pick-Up ☐ Mailed ☐ Faxed ☐ Electronic

Verification of ID: ☐ Photo ID ☐ Person is known to me ☐ Government Credentials

Verified by: *(CMH Staff Signature):* ____

Medical Record Number________________________

PATIENT STICKER

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