

Authorization to Release Healthcare Information from CBH/CBFM

Patient	Patient's Name:	Address:	
	Date of Birth:	(City, State, Zip):	
	Other Names Used:	Phone Number	
Authorization	INFORMATION TO BE RELEASED FROM:	INFORMATION TO BE RELEASED TO:	
	<input type="checkbox"/> Columbia Basin Hospital	<input type="checkbox"/> Self (same as above) <input type="checkbox"/> Other: _____	
	200 Nat Washington Way, Ephrata, WA 98823	Provider Name/Organization:	
	Phone: 509-754-4631 Fax: 509-622-2712	Address:	
	<input type="checkbox"/> Columbia Basin Family Medicine	(City, State, Zip):	
	220 Nat Washington Way, Ephrata, WA 98823	Phone:	
	Phone: 509-754-3330 Fax: 509-622-2712	Fax:	
		(Facility only. We do not fax directly to patient's personal fax number.)	
Delivery Options: <input type="checkbox"/> Mail <input type="checkbox"/> Pick-Up <input type="checkbox"/> CD			
Information	Purpose of Disclosure: <input type="checkbox"/> Continuation of Care <input type="checkbox"/> Personal <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Other: _____		
	Notice: I understand that there may be charges associated with my request for records. Records will be made available no later than 15 working days. If the request is denied or the information requested does not exist or cannot be found the patient will be notified within 15 working days. (RCW 70.02.080, 70.02.090)		
Information	Release the Following Records:		
	<input type="checkbox"/> Abstract/Summary (Hospital Records) (includes history and physical, progress notes, consultations & test results)	<input type="checkbox"/> From: _____	To: _____
	<input type="checkbox"/> Last 2 years Transfer of Care (Family Medicine) No Charge	<input type="checkbox"/> From: _____	To: _____
	<input type="checkbox"/> Imaging Reports (X-ray, MRI, etc. <input type="checkbox"/> Image CD	<input type="checkbox"/> From: _____	To: _____
	<input type="checkbox"/> Billing and Payment Records	<input type="checkbox"/> From: _____	To: _____
	<input type="checkbox"/> Other Records: _____	<input type="checkbox"/> From: _____	To: _____
Restrictions	Sensitive Information: I understand that all healthcare information in my records, including testing and diagnosis for HIV, sexually transmitted diseases, psychiatric disorders/mental health, drug and/or alcohol use will be released unless initialed below. Do NOT send records regarding (check & initial all that apply): <input type="checkbox"/> HIV/AIDS _____ <input type="checkbox"/> STDs _____ <input type="checkbox"/> Psychiatric Disorders/Mental Health _____ <input type="checkbox"/> Drug/Alcohol Abuse _____		
	Revocation: I understand that I have the right to revoke this authorization at any time except to the extent that Columbia Basin Hospital/Columbia Basin Family Medicine has taken action in reliance on the authorization. To revoke this authorization, I must submit a written revocation to: Privacy Office at Columbia Basin Hospital, 200 Nat Washington Way, Ephrata, WA 98823		
	Expiration: This Authorization ends (Please check ONE of the following options): <input type="checkbox"/> in 90 days from the date signed <input type="checkbox"/> one year from the date signed <input type="checkbox"/> other: _____ (No longer than one year from the date signed)		
	Disclosure: I understand that Columbia Basin Hospital/Columbia Basin Family Medicine may not condition the Patient's healthcare on this authorization unless (1) the purpose of Columbia Basin Hospital/Columbia Basin Family Medicine's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research. I understand that information disclosed by Columbia Basin Hospital/Columbia Basin Family Medicine pursuant to this authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations.		
Signature	Patient or legally authorized individual signature	Date	Relationship to Patient (parent, legal guardian, personal representative) Guardianship papers or power of attorney papers are required.
	Minor Signature (signature of minor is also required if minor is age 13-17*)	Date	*RCW 9.02.100 (100), State v. Koome, 84 Wn.2d 901, RCW 70.24.110, RCW 70.96A.095, RCW 71.34.500 & RCW 71.34.530

For Facility Use:

Date Received: _____ Date Information Requested: _____ MRN #: _____

Person/Department Sending Records: _____