Lincoln County Public Hospital District #3

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION AND RECORDS

Patient Name_____ Date of Birth ____/____/_____ Phone _____
FIRST MIDDLE INITIAL LAST

Health Care Information and Records to be: ☐Mailed, ☐Faxed, ☐Hand-Given to Patient/Family/Friend (please indicate below)
To be release in electronic format: ☐MyChart Secure Patient Portal, ☐CD, ☐USB Flash Drive (provided by patient)

Information/Records released ☐to: ☐from: (please check one)	Information/Records released ☐to: ☐from: (please check one)
Name	Name *North Basin Medical Clinics* *(provider)*
Address	Address *100 3rd Street, Suite 1*
City/State/Zip	City/State/Zip *Davenport, WA 99122*
Phone	Phone *509-725-7501*
Fax or E-mail	Fax *509-622-2690*

TYPES OF INFORMATION TO BE RELEASED:

I permit the above named "from" provider to release the following health care information to the above named "to" provider. I understand that the "from" provider needs my written authorization to release any health care information about testing, diagnosis, procedures and/or treatment for *alcohol and/or chemical dependency, reproductive health, sexually transmitted diseases (including HIV/AIDS), psychiatric disorders/mental illness.* Based on the box(es) I have checked below, the provider may release all diagnostic, treatment information and records, except psychotherapy notes as defined by the Health Insurance Portability and Accountability Act of 1996, which requires a separate authorization.

_____ *Initials*

☐ Immunization Record (Child Profile) ☐ Laboratory/Radiology ☐ Medication List
☐ Office visits ☐ Other_____

Date(s) of Service_____ or Most recent ☐ two (2) years (include most recent colonoscopy/path, mammo, DEXA, Pap, diabetic eye/foot exams, hepatitis C screening, surgical reports)

PURPOSE FOR RELEASE AND HOW INFORMATION WILL BE USED:

☐ At the request of the Patient ☐ Coordination of Care ☐ Legal Review/Proceedings
☐ Discuss Health Care Info with Family or Friend(s) named above with ☐*No Expiration Date* ☐ Other_____

REVOCATION OF RELEASE:

I understand that I may change my mind and revoke this release at any time. I will do this by letting the provider know of my decision. Any change will be effective five (5) business days after receipt of written notice. I understand that some or all of this information may already have been shared and that the provider will not be liable for any information already released.

RE-DISCLOSURE:

Information disclosed as a result of this authorization may be disclosed by the party listed above as the recipient, and may no longer be protected by state and federal privacy rules.

NO CONDITIONS:

This authorization is voluntary. We will not condition your receipt of treatment on giving this authorization.

TIME FRAME OF RELEASE:

Unless otherwise specified or I revoke it, this release will remain valid for ninety (90) days from the date of my signature below.

CONSENT OF MINOR:

A minor patient's signature is required in order to release information concerning care for: 1) conditions relating to the minors sexuality including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization and sexually transmitted disease; 2) alcoholism or drug abuse; and 3) mental health conditions. [Age fourteen (14) and above for drug and/or alcohol related information or information related to sexuality; age thirteen (13) and above for mental health information.]

*Signature_____ Today's Date____/____/____

Print Name_____
FIRST MIDDLE INITIAL LAST

*If not the patient, I am the: ☐ Parent, or
☐ Legal Guardian** ☐ Holder of Power of Attorney for Health Care**

**Attach a copy of legal documentation if you are the legal guardian or holder of a power of attorney for the patient.

OFFICE USE *Records Released by*_____ *Date*_____

Person making the request's identity has been verified with photo identification

_____
Office Personnel

or

Attach copy of photo identification

Lincoln County Public Hospital District #3
AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION AND RECORDS

Purpose: This form authorizes Lincoln County Public Hospital District #3 (Lincoln Hospital) to use or disclose your protected health information for a particular purpose other than to carry out treatment, payment or healthcare operations. If this authorization is for psychotherapy notes, it may not be used as an authorization for any other type of protected health information.

The Individual Confirming the Authorization: I authorize the use and/or disclosure of my protected health information as described below. I understand this authorization is voluntary and made to confirm my direction. I understand that Lincoln Hospital may not condition the provision of medical treatment upon my signing this authorization unless the provision of such treatment is for disclosure to a third party. I understand that, if the persons or organizations I authorize below to receive and/or use the protected health information described below are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

The Use and/or Disclosure Being Authorized: Specifically and meaningfully describe the protected health information you are authorizing Lincoln Hospital to use and/or disclose (if this authorization is for psychotherapy notes, no other type of protected health information may be listed on this authorization) and the purpose of the use or disclosure.

ACCESS REQUEST

Purpose: This form is used for an individual's request and/or to obtain copies of the individual's protected health information or records maintained in Lincoln Hospital's designated record sets or the designated record sets of a business associated of Lincoln Hospital.

Right to Inspect and/or Obtain Copy: You have the right to inspect and/or obtain a copy of your protected health information in designated record sets Lincoln Hospital, or its business associates maintain. You are not, however, entitled to inspect or obtain a copy of any psychotherapy notes Lincoln Hospital may have, any information we may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, any information not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a), and certain other records.

Lincoln Hospital has the right to charge for the copies; the fees to copy these records are $26.00 Search/Base Fee, $1.17 first 30 pages, $0.88 each additional page plus tax, based on Department of Health Amended Rule on Allowable Fees for Searching and Duplicating Medical Records (WAC 246-08-400) effective September 7, 2017 through June 30, 2019. If you want the copies mailed, you will be required to pay for the postage and handling.

Lincoln Hospital must respond to an access request within 30 days of its receipt, unless the requested records are off-site. We then have 60 days to respond.

Extension of response date: We may take one 30-day extension of our response date by notifying the requester within the original 30 - 60 day response period of the reason for the extension and the date on which we will provide our response.

Laboratory Results: Requesting Laboratory results can be done for specific tests (Comprehensive Metabolic Profile/CMP, Lipid Profile, CBC, TSH, PSA, Glycohemoglobin, and Dilantin) and provided by;

1. Physician or provider order for the test, that also states, "Provide results to the patient when available," and
2. A completed REQUEST Form.

Person making the request's identity has been verified with photo identification. _____ Initials of Laboratory

☐ Patient Chart Copy ☐ Laboratory Copy