Prosser Specialty Clinic
Prosser Memorial Health

Authorization to Obtain or Disclose Health Care Information

Patient Name: _____ **Date of Birth:** _____
Previous Name: _____ **Phone #:** _____

Release records from:		**Release records to:**	
Facility/Name:	**Prosser Specialty Clinic**	Facility/Name:	_____
Address:	**820 Memorial Street Suite 3**	Address:	_____
	PROSSER, WA 99350		_____
Phone #:	**(509) 786-5599**	Phone #:	_____
Fax #:	**(509) 786-2349**	Fax #:	_____

You may disclose the following health care information:

☐ Diagnostic Imaging and Reports on CD (fee may apply).
☐ Two years of health care information in my record up to and including the most recent dates of service.
☐ Health care information in my record relating to the following treatment and/or dates of service:
_____

Do NOT send records regarding (check any that apply):

☐ HIV/AIDS ☐ Sexually Transmitted Diseases
☐ Psychiatric Disorders/Mental Health ☐ Drug and/or Alcohol Use

Reason(s) for this authorization (check all that apply):

☐ Patient Personal Use (a fee may apply) ☐ Transfer of Care / Continuity of Care
☐ Legal (a fee may apply) ☐ Insurance ☐ Other: _____

Release my records in the following format:

☐ Paper ☐ Fax ☐ Electronic (media, flash drive, CD) ☐ My Chart (maximum file size to release is 1.0 GB)
☐ Mail ☐ Pick up by the following individual: _____

This authorization will automatically end 90 days after the date it is signed, unless an earlier date is specified

☐ This authorization ends: _____

Patient Rights

I understand that I may not be able to revoke this authorization if its purpose was to obtain insurance. Otherwise, I may revoke this authorization at any time. Revoking this authorization will not affect any actions already taken by PMH Medical Center. I may revoke this authorization by:

1) Filling out a revocation form, or
2) Writing a letter to notify the Health Information Management Department at PMH Medical Center.

I understand that if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal and state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information

_____ _____
Patient signature (or legally authorized individual) **Date**

_____ _____
Printed name (if signed on behalf of the patient) **Relationship to patient**