Prosser Memorial Health

# Authorization to Obtain or Disclose Health Care Information

Contact Information: Phone #: 509-786-6663 Fax #: 509-786-2349

**Patient Name:** _____ **Date of Birth:** _____

**Previous Name:** _____ **Phone #:** _____

| **Release records from:** | | **Release records to:** | |
|---|---|---|---|
| Facility/Name: | **PROSSER THERAPY SERVICES** | Facility/Name: | |
| Address: | **326 Chardonnay Ave** | Address: | |
| | **PROSSER, WA 99350** | | |
| Phone #: | **509-786-6626** | Phone #: | |
| Fax #: | **509-786-6712** | 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:

_____

**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: _____

**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: _____

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

☐ This authorization ends: _____

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**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**

**FOR OFFICE USE ONLY**

| | |
|---|---|
| ☐ Driver's License #_____<br>☐ Other: _____ | MRN: _____<br>Date of Release: _____<br>ID Verified by:_____ |