Prosser Memorial Health

723 Memorial Street
Prosser, WA 99350

Also, serving Prosser and Benton City Family Clinic, Prosser Specialty Clinic, Prosser Therapy Services and Occupational Health Clinics.

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 MEMORIAL HEALTH**	Facility/Name:	
Address:	**723 MEMORIAL STREET**	Address:	
	PROSSER, WA 99350		
Phone #:	**509-786-6663**	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:

_____

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

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

☐ Patient Personal Use (a fee may apply)
☐ Legal (a fee may apply)
☐ Transfer of Care / Continuity of Care
☐ 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 #_____ ☐ Other: _____	MRN: _____ Date of Release: _____ ID Verified by:_____