



HIM/MEDICAL RECORD DEPARTMENT
PHONE: 509-4735388 FAX: 509-473-5903

MR# _____(office use only)

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name: _____ Date of Birth: _____ SS#: _____
Print name of patient

This authorization is voluntary. I authorize the use or disclosure of the healthcare information described below to be released from and sent to the following:

Information to be released FROM: Valley Hospital and Medical Center, 12606 East Mission, Spokane, WA 99216
Name of Facility or Provider

Information to be released TO: _____
Name of Recipient
Address
City State Zip Code Telephone

Information to be released:
The most recent two (2) years of physician reports, lab, x-ray, special tests
All medical records concerning this patient
Specific Information (please specify) _____

Purpose for which disclosure is being made*: (Please check one of the following)

Legal Insurance Treatment Personal
*A processing fee may be required.

Hospital Use Only
Fee Required? Yes/No
Picking Up Records? Yes/No
Pick-up Instructions: _____

Specify Authorization:

I understand that my records may contain information regarding the testing, diagnosis and/or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for those records to be released.

*If patient has reached his/her thirteenth (13th) birthday, ONLY the patient can authorize disclosure relating to the above specified conditions.

My Rights:

I understand I have a right to request and receive a Notice of Privacy Practices. I may inspect and receive a copy (a nominal fee may be charged). Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing the authorization. I may revoke this authorization in writing by presenting it as provided in the Notice of Privacy Practices for the Facility, but the revocation will not apply to information already used or disclosed. I understand that once the health information I authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. The provider must make the healthcare information available within fifteen (15) working days after receiving the request or notify the patient of any delay. (RCW 70.02.080)

Expiration: This authorization expires _____ (insert applicable date MM/DD/YY). I understand this authorization will expire ninety (90) days from the date signed if no specific expiration date is indicated.

SIGNATURE: _____ DATE: _____
Identify status if signed by patient, guardian, authorized representative and provide documentation of authority.

Employee accepting release: _____ Copy of ID reviewed by: _____
Employee releasing records: _____ Information Released _____