COLUMBIA BASIN HOSPITAL — FAMILY MEDICINE
A LEGACY OF CARE SINCE 1950

Authorization to Release Healthcare Information to CBH/CBFM

Patient	Patient's Name:	Address:
	Date of Birth:	(City, State, Zip):
	Other Names Used:	Phone Number
Authorization	**INFORMATION TO BE RELEASED FROM:**	**INFORMATION TO BE RELEASED TO:**
	Provider Name/Organization:	☐ **Columbia Basin Hospital**
	Address:	200 Nat Washington Way, Ephrata, WA 98823
	(City, State, Zip):	Phone: 509-754-4631 Fax: 509-622-2712
	Phone:	☐ **Columbia Basin Family Medicine**
	Fax:	220 Nat Washington Way, Ephrata, WA 98823
	(Facility only. We do not fax directly to patient's personal fax number.)	Phone: 509-754-3330 Fax: 509-622-2712
	Delivery Options: ☐ Mail ☐ Pick-Up ☐ CD	

Information

Purpose of Disclosure: ☐ Continuation of Care ☐ Personal ☐ Transfer of Care ☐ Insurance ☐ Legal ☐ Other:_____

Notice: I understand that there may be charges associated with my request for records. Records will be made available no later than 15 working days. If the request is denied or the information requested does not exist or cannot be found the patient will be notified within 15 working days. (RCW 70.02.080, 70.02.090)

Release the Following Records:

☐ Abstract/Summary (Hospital Records) (includes history and physical, progress notes, consultations & test results)	☐ From: _____ To: _____
☐ Last 2 years Transfer of Care (Family Medicine) No Charge	☐ From: _____ To: _____
☐ Imaging Reports (X-ray, MRI, etc. ☐ Image CD	☐ From: _____ To: _____
☐ Billing and Payment Records	☐ From: _____ To: _____
☐ Other Records: _____	☐ From: _____ To: _____

Restrictions

Sensitive Information: I understand that all healthcare information in my records, including testing and diagnosis for HIV, sexually transmitted diseases, psychiatric disorders/mental health, drug and/or alcohol use will be released unless initialed below.
Do **NOT** send records regarding (check & initial all that apply):
☐ HIV/AIDS _____ ☐ STDs _____ ☐ Psychiatric Disorders/Mental Health _____ ☐ Drug/Alcohol Abuse _____

Revocation: I understand that I have the right to revoke this authorization at any time except to the extent that Columbia Basin Hospital/ Columbia Basin Family Medicine has taken action in reliance on the authorization. To revoke this authorization, I must submit a written revocation to: Privacy Office at Columbia Basin Hospital, 200 Nat Washington Way, Ephrata, WA 98823

Expiration: This Authorization ends (Please check ONE of the following options): ☐ in 90 days from the date signed
☐ one year from the date signed ☐ other: _____ (No longer than one year from the date signed)

Disclosure: I understand that Columbia Basin Hospital/Columbia Basin Family Medicine may not condition the Patient's healthcare on this authorization unless (1) the purpose of Columbia Basin Hospital/Columbia Basin Family Medicine's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research. I understand that information disclosed by Columbia Basin Hospital/Columbia Basin Family Medicine pursuant to this authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations.

Signature

Patient or legally authorized individual signature	**Date**	**Relationship to Patient** (parent, legal guardian, personal representative) _____ **Guardianship papers or power of attorney papers are**
Minor Signature (signature of minor is also required if minor is age 13-17*)	**Date**	*RCW 9.02.100 (100), State v. Koome, 84 Wn.2d 901, RCW 70.24.110, RCW 70.96A.095, RCW 71.34.500 & RCW 71.34.530

For Facility Use:

Date Received: _____ Date Information Requested: _____ MRN #: _____

Person/Department Sending Records: _____