

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:	<input type="checkbox"/> Columbia Basin Hospital	
	Address:	200 Nat Washington Way, Ephrata, WA 98823	
	(City, State, Zip):	Phone: 509-754-4631 Fax: 509-754-2351	
	Phone:	<input type="checkbox"/> 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: 509-754-2351	
Delivery Options: <input type="checkbox"/> Mail <input type="checkbox"/> Pick-Up <input type="checkbox"/> CD			
Information	Purpose of Disclosure: <input type="checkbox"/> Continuation of Care <input type="checkbox"/> Personal <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Other: _____ <u>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)</u>		
	Release the Following Records: <input type="checkbox"/> Abstract/Summary (Hospital Records) <input type="checkbox"/> From: _____ To: _____ <small>(includes history and physical, progress notes, consultations & test results)</small> <input type="checkbox"/> Last 2 years Transfer of Care (Family Medicine) No Charge <input type="checkbox"/> From: _____ To: _____ <input type="checkbox"/> Imaging Reports (X-ray, MRI, etc. <input type="checkbox"/> Image CD <input type="checkbox"/> From: _____ To: _____ <input type="checkbox"/> Billing and Payment Records <input type="checkbox"/> From: _____ To: _____ <input type="checkbox"/> Other Records: _____ <input type="checkbox"/> 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. <u>Do NOT send records regarding (check & initial all that apply):</u> <input type="checkbox"/> HIV/AIDS _____ <input type="checkbox"/> STDs _____ <input type="checkbox"/> Psychiatric Disorders/Mental Health _____ <input type="checkbox"/> 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): <input type="checkbox"/> in 90 days from the date signed <input type="checkbox"/> one year from the date signed <input type="checkbox"/> other: _____ (No longer than one year from the date signed)		
Signature	Patient or legally authorized individual signature		Date
	Minor Signature (signature of minor is also required if minor is age 13-17*)		Date
		Relationship to Patient (parent, legal guardian, personal representative) _____ Guardianship papers or power of attorney papers are _____ <small>*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</small>	

For Facility Use:

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

Person/Department Sending Records: _____