

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please respond to Health Information Management

Fax: 509-225-2702

Phone: 509-248-3263

Patient Name: _____ Prior Name: _____

Date of Birth: _____ Medical Record (YVMH ONLY): _____

I authorize: _____
Hospital, physician, program, agency

_____ *Address*

_____ *Phone and Fax*

to release my confidential records to:

_____ *Self, Hospital, physician, program, agency*

_____ *Address*

Reason for Disclosure _____

THE SPECIFIC INFORMATION TO BE RELEASED:

Dates of treatment: (from) _____ (to) _____

- All of the following (or mark individual boxes for only specific information to be released)
- | | | |
|---|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Report of Operation | <input type="checkbox"/> X-Ray Reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> EKG Reports |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Emergency Dept. Record | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Other: _____ | |

Includes

Excludes

-

-

- Drug or alcohol abuse diagnosis/treatment
Mental Health records
HIV or AIDS testing/treatment
Confirmed sexually transmitted disease (STD)

*This authorization will automatically expire after 90 days or on this date specified: _____.
You may revoke this authorization at any time by notifying the Health Information Management Department in writing. Revocation of this authorization cannot be retroactive to a release of information made in good faith. I understand that once the health information I have authorized to be disclose reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. We will not withhold treatment if you do not sign this authorization. There is a potential that the recipient as described above could redisclose your protected health information.*

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. Portions that I did not understand have been explained to me.

Patient or legal representative

Date and Time

Authority to sign, if not the patient

Witness