



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Phone: 509-773-4022

Fax: 509-773-4543

310 S. Roosevelt, Goldendale, WA 98620

Patient Name:	Date of Birth:
Address:	Phone Number:
Purpose for the release:	

I request and authorize records to be:

☐ **Released to:**

☐ **Released from:**

Name:		Phone Number:
Address:		Fax Number:
City:	State:	Zip Code:

The following specific information is selected to be disclosed:

- | | | | |
|--|--|---|--|
| ☐ Medical Records | ☐ Radiology Reports | ☐ Labs/Pathology | ☐ Immunizations |
| ☐ Chart Notes | ☐ Billing Statement | ☐ Other _____ | |

Time Frame Requested _____

Patients who request more than the last two years of records for personal use may be charged a \$10 service fee. All records will be burned to a CD or Faxed. If paper copies are requested, there will be an additional charge.

The information that is disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law. However, federal or state law may restrict re-disclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

*The following items must be initialed to be included in the use/disclosure of other medical information:

- _____ *AIDS/HIV and other Communicable Disease
- _____ *Behavioral health Care/Psychiatric Care/Mental Health Information
- _____ *Alcohol and/or Drug Abuse
- _____ *Genetic Testing Information

The person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so.

You do not need to sign this authorization/ Refusal to sign the authorization will to adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Klickitat Valley Health Medical Records Department and state that you are revoking this authorization.

I have read this authorization and I understand it. This authorization expires in 90 days from the date signed unless otherwise specified.

Signature of Patient or Patient's Legal Representative

Date / Time

Print Name (proof of authority to sign may be required)

Relationship to Patient

KVH Staff Signature

Date / Time