



Consent for Release of Information

Patient name:		Maiden/nickname/other names:
Mailing Address:		Date of birth:
City, state, zip code:		Phone:
Please obtain information from:		Please send my information to:
Name:	Name:	Title (self, physician, attorney, etc.):
Address:	Address:	
City, state, zip code:	City, state, zip code:	
<input type="checkbox"/> Please call when records are ready for pick up.* <input type="checkbox"/> Please mail records.* <input type="checkbox"/> Please fax records.*	Fax:	Phone:

I authorize above named Hospital, Clinic or Physician to release the following protected health information:

Specific treatment date(s) or admission(s): _____

Specific information as listed below:

- | | | |
|---|--|---|
| <input type="checkbox"/> X-ray CD | <input type="checkbox"/> Laboratory report | <input type="checkbox"/> Emergency report |
| <input type="checkbox"/> X-ray report | <input type="checkbox"/> History & Physical report | <input type="checkbox"/> Progress note |
| <input type="checkbox"/> Operative report | <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Other: |

I understand that certain information in these records cannot be released without specific authorization because of Federal and/or State law. **By initialing below**, I specifically authorize the release of the following confidential and protected health information:

_____ HIV test and/or other sexually transmitted disease test results and related information, including documentation of high-risk behavior.

_____ Genetic testing results and related information.

_____ Drug and/or alcohol diagnosis, treatment and/or referral information.

_____ Mental health treatment information.

My consent may be revoked at any time. The only exception is when the action has already occurred as instructed in this Consent.

This Consent will expire one year from date of signature below.

Patient signature:	Parent/Legal Guardian signature (if applicable):
Date:	Witness signature:

*Please allow **14 days** for completion of your record request. There is **no charge** for records provided to patients or physicians and hospitals **for continuity of patient care**.

Release of Information Clerk | P: 509-637-2943 | F: 509-493-4057

For official use only:

Date records sent: _____ Sent via: Mail Fax Picked up (by: _____)

Copy of release sent to: _____ on: _____