AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION (1 OF 2)

Yakima Valley Memorial, 2811 Tieton Drive, Yakima, Washington 98902-Release of Information Fax: 509-575-8685

See back page for instructions to fill out this form. Failure to follow instructions can result in processing delay.

1. PATIENT INFORMATION

Patient Name ____________________ Date of Birth ____________________

Phone Number ____________________ Medical Record # (ifknown)____________________

2. INFORMATION TO BE RELEASED FROM (SELECT ONLY ONE)

☐ Yakima Valley Memorial Hospital

☐ Yakima Valley Memorial provider/clinic(s) **(please specify)** ____________________

☐ Organization/Person ____________________

Address ____________________ City, State, Zip ____________________

Phone ____________________ Fax ____________________

3. INFORMATION TO BE RELEASED TO (SELECT ONLY ONE)

☐ Yakima Valley Memorial Provider/Clinic(s) **(please specify)** ____________________

☐ Organization/Person ____________________

Address ____________________ City, State, Zip ____________________

Phone ____________________ Fax ____________________

4. PURPOSE OF RELEASE

☐ Continuing care

☐ Copies for own use

☐ Insurance

☐ Legal

☐ Other (specify below)

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5. INFORMATION TO BE RELEASED

Medical records: date from: ____________________ **to:** ____________________

☐ **All records within the date range provided**

☐ Discharge summaries

☐ Operative reports

☐ Emergency department records

☐ Clinic notes

☐ Lab/pathology reports

☐ Radiology images (on CD) - Valley Imaging

☐ Immunizations

☐ Radiology reports

☐ Other (please specify) ____________________

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MY RIGHTS / MY AUTHORIZATION

I understand that authorizing the disclosure of this patient health information is voluntary. I understand that I do not need to sign this form in order to assure treatment or payment. I understand that unless expressly limited by me in writing, I am **specifically authorizing** the release of any sensitive medical information that may appear in my medical record including records for mental health **treatment** including pain management; sexually transmitted diseases; AIDS/HIV treatment; and program records

I can cancel this authorization at any time by writing to the Health Information Management Department, as also described in Yakima Valley Memorial's Notice of Privacy Practices. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled. Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws. **This authorization will expire 1 year from the date signed below unless another date or event is entered here** ____________________

Note: If the disclosure is to an employer or financial institution for purposes other than payment, this authorization will expire 1 year from the date signed by you.

6. SIGNATURE

Signature of Patient or Legally Responsible Party ____________________ Date ____________________

(If not signed by patient, see information on back page.)

Relationship to patient, if not signed by patient ____________________

MINOR PATIENT (age 13-17)____________________ Date ____________________

CLINICAL STAFF

____
PATIENT NAME & ID #

YAKIMA VALLEY MEMORIAL

Authorization to Release Patient Health Information

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION (2 OF 2)

Instructions – **Please print legibly.** Failure to follow instructions can result in a delay in processing your request.

1. PATIENT INFORMATION. Print patient's name, date of birth, phone number and medical record number (if known).
2. INFORMATION TO BE RELEASED FROM. Select **Yakima Valley Memorial Hospital** **OR** select **Yakima Valley Memorial Provider/Clinic(s)** and write the name(s) of specific provider(s). If this form is used to request records outside of Yakima Valley Memorial, select **Organization/ Person** and write the address, phone and fax information.
3. INFORMATION TO BE RELEASED TO. Select **Organization/Person** and provide the address of the organization or person that is to receive copies of the information. Select **Yakima Valley Memorial Provider(s)** if the form is used to send records to a Yakima Valley Memorial Provider and indicate the specific provider that is to receive copies of the information.
4. PURPOSE OF RELEASE. Select the reason records are being requested.
5. INFORMATION TO BE RELEASED. Specify what information is to be released.
6. SIGNATURE. Sign and indicate date signed.
   If not signed by patient, documentation may be required to prove authority to sign on behalf the patient. Please read information below:

AUTHORIZED PERSONAL REPRESENTATIVE FOR ADULT PATIENTS NOT COMPETENT

A personal representative is an individual who may act on behalf of a patient when the patient lacks decision-making capacity to make health care treatment decisions. The personal representative may need legal documentation to demonstrate authority to sign for the patient. A member of one of the following classes of persons may sign for an adult patient who lacks capacity to consent, in the following order of priority: (a) the appointed guardian of the patient, if any; (b) the individual, if any, to whom the patient has given a durable power of attorney that includes the authority to make health care decisions; (c) the patient's spouse or state registered domestic partner; (d) children of the patient who are at least eighteen years of age; (e) parents of the patient; and (f) adult brothers and sisters of the patient. If a person is not available in a given class to provide authority regarding health care decisions, then a person (or group of persons acting as one) must be found in the next successive class. [RCW 7.70.065(1)].

AUTHORIZED PERSONAL REPRESENTATIVE FOR MINORS

A member of one of the following classes of persons may sign for a minor patient in the following order of priority: (a) the appointed guardian or authorized legal custodian (Title 26); (b) a person appointed by the court to consent to medical care for a child in out of home placement pursuant to RCW 13.32A or RCW 13.34; (c) parents; (d) an individual to whom a parent has given a signed authorization to make health care decisions for the child; and (e) an adult representing him or herself as responsible for the health care of the minor (a health care provider may, at its discretion, require documentation of this person's claimed status). [RCW 7.70.065(2)]

Note: Under state law each parent has full and equal access to the health care records of their child absent a court order to the contrary. Neither parent may veto the access requested by the other parent. [RCW 26.09.225]

A minor patient's signature is required to release the following information:

1) Information related to reproductive care such as birth control and pregnancy-related services;
2) Sexually transmitted diseases, including HIV/AIDS (age 14 and older);
3) Substance abuse and mental health treatments (age 13 and older).

Send completed **Authorization to Release Patient Health Information** form by mail or byfax:

ADDRESS: Attn: Health Information Management
Yakima Valley Memorial
15 West Yakima Ave, Ste #100
Yakima, Washington 98902

REQUESTS FOR:	FAX	PHONE
Medical Records	509-575-8685	509-575-8082
Valley Imaging/Images on CD	509-457-3244	509-248-7380

PATIENT NAME & ID #

YAKIMA VALLEY MEMORIAL– Yakima WA

Authorization to Release Patient Health Information

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