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)

☐ Discharge Summary	☐ Report of Operation	☐ X-Ray Reports
☐ History & Physical	☐ Pathology Report	☐ EKG Reports
☐ Consultations	☐ Emergency Dept. Record	☐ Lab Reports
☐ Progress Notes	☐ 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