Authorization for the Use, Disclosure or Release of Protected Health Information

411 Fortuyn Rd. Grand Coulee, WA. 99133
Ph: 509-633-1753 Fax: 509-633-3644

COULEE MEDICAL CENTER

Section 1 **Patient Information:** **Medical Record #:**

Patient Name: _____

Date of Birth: _____ (Month Day Year) Social Security: _____ Phone Number: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Section 2 **Information to be released by: (Person/Organization providing the information)**

Name of Office/Facility: _____ Attn: _____

Address: _____ (Street) _____ (City) WA (State) _____ (Zip Code)

Phone Number: _____ Fax Number: _____

Section 3 **Information to be released to: (Person/Organization receiving the information)**

Name of Recipient: Coulee Medical Center Attn: Medical Records

Address: 411 Fortuyn Road (Street) Grand Coulee (City) WA (State) 99133 (Zip Code)

Phone Number: (509) 633 - 1911 Fax Number: (509) 633 - 1933

Section 4 **Information Requested: (Please select one)**

_____ Most recent 2 years of relevant information (visit notes, lab results, radiology findings, pathology reports, operative, and procedure notes)

_____ Specific information (please specify, i.e., immunization records) _____

_____ All medical records

_____ Employment/Sports physical

Please specify how you would like to receive your medical records:

Mail: ☐ Fax: ☐ Pick Up At CMC: ☐

Section 5 **Purpose for which the disclosure is being made: (Please select one)**

_____ Legal _____ Insurance X Continuity of Care _____ Personal Use _____ Military

*I understand that my medical record may also include information on diagnosis/treatment related to **psychiatric or psychological conditions, drug and/or alcohol abuse, sexually transmitted diseases (STD), acquired immune deficiency syndrome (AIDS), and/or HIV status.**

*I understand and agree that unless I specify otherwise, all medical information including the diagnosis and treatments described above may be released.

Please initial this statement if you do **not** authorize the release of the information described above. ☐ I do **not** authorize the release of the information listed above.

- I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
- I understand that Coulee Medical Center will not deny treatment or payment based upon whether I sign this authorization.
- I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization.
- I understand that I am entitled to a copy of this authorization after I sign it.

Signature of patient/legal representative: _____ Date: _____

Relationship to patient, if other than patient: _____

Signature of witness if applicable: _____ Date: _____

CMC Staff use only:** ***Release of information completed by: _____ ***Date:*** _____

There may be a charge for your medical records unless the copies are being sent to another physician or healthcare facility

This authorization will expire 60 days from the date signed.

Revised 8.26.15