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



Patient Name:	Patient Inforn	nation:			Medical Reco	ord #:
Patient Name.						
Date of Birth:			Social Security:		Phone Num	ber:
	Month D	ay Year	_		_	
Address:		Street		City	State	Zip Code
Section 2	Information to		(Person/Organizat	,		Zip couc
	illiorillation t	o be released by.	(Person/Organizat	, ,	iioiiiatioiij	
Name of Office/Facility:	-			Attn:		
Address:		<u> </u>		0.1	WA	7: 0 1
Phone Number:		Street		City Fax Number:	State	Zip Code
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Section 3	Information to	o be released to:	(Person/Organizati	on receiving the in	formation)	
Name of Recipient:		Coulee Med	ical Center	Attn:	Med	dical Records
Address:	41	.1 Fortuyn Road	(Grand Coulee	WA	99133
		Street		City	State	Zip Code
Phone Number:	(509) 6	533 - 1911		Fax Number:	(509) 63	33 - 1933
Section 4	Information R	Requested: (Pleas	e select one)			
	years of relevan	nt information (vi	sit notes, lab results	, radiology findings,	, pathology repo	rts, operative, and
procedure note		•				•
Specific inform	ation (please sp	ecify, i.e., immur	nization records)			
All medical rec	ords					
Employment/S						
Please specify how you w		eive your medical	records:			
		lp At CMC:				
Section 5	Purpose for w	hich the disclosu	re is being made: (I	Please select one)		
Legal	Insura				sonal Use	Military
	Insura	nnce X	Continuity of Care	e Pers		
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*I understand that my me conditions, drug and/or a	Insura	ay also include in	Continuity of Care	e Personsis/treatment relat	ed to psychiatri	c or psychological
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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.