

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

411 Fortuyn Rd.
Grand Coulee, WA 99133
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Section 1: Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

Please specify how you would like to receive your medical records (**PLEASE CHECK ONE**):

- Mail Fax Pick-up at CMC (*photo ID Required*)

Section 2: Authorization to Release and Receive Information

I authorize my medical records to be **RELEASED FROM Coulee Medical Center** to the entity listed below

I authorize my medical records to be **PROVIDED TO Coulee Medical Center** to the entity listed below

Entity Name/Organization: _____ Provider: _____

Address: _____
Street City State Zip

Phone Number: _____ Fax Number: _____

Section 3: Information Requested

- | | | |
|--|---|--|
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Office Visit Notes | <input type="checkbox"/> Physical Therapy Notes |
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Radiology Report(s) | <input type="checkbox"/> Emergency Room Record |
| <input type="checkbox"/> Medication List | <input type="checkbox"/> Laboratory Result(s) | <input type="checkbox"/> Other (<i>specify</i>): _____ |

Date(s) of Service: _____ **Or** Most recent _____ Month(s), Year(s) of Records

Section 4: Sensitive Information and Substance Use Disorder (SUD) Authorization

Sensitive information and SUD records will NOT be released unless specifically authorized below.

(Please check each item you agree to release):

- Mental Health Treatment Records HIV/AIDS – Related Information Sexually Transmitted Disease (STD) Information

Substance Use Disorder Records (42 CFR Part 2):

- I authorize the release of my SUD records **I DO NOT AUTHORIZE** the release of my SUD records

Section 5: Purpose of Disclosure (PLEASE CHECK ONE):

- Continuity of Care Personal Use Insurance/Benefits Legal Military Other: _____

Section 6: Patient Rights and Notices

- Signing this authorization is voluntary and not required for treatment, payment, enrollment, or eligibility for benefits
- I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it
- I may request a copy of this authorization
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA, except where prohibited by law, including 42 CFR Part 2
- Washington law provides additional protections for sensitive health information

If you have questions about this authorization or your privacy rights, you may contact **Coulee Medical Center's Privacy Officer**

Signature of patient/legal representative: _____ Date: _____

Relationship to patient (*if not patient*): _____

This authorization expires **one (1) year from the date signed**, unless otherwise specified: **Date/Event:** _____

***CMC Staff use only:** Completed by: _____ Date: _____ Medical Record # _____
CMC may charge for copies of medical records unless records are sent directly to another healthcare provider