MR#_____

**COLUMBIA BASIN HEALTH ASSOCIATION**
1515 E Columbia St, Othello, WA 99344
Phone: 509-488-5256
Fax: 509-331-1601 or 509-488-9939

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT'S NAME:_____ D.O.B.:_____

PREVIOUS NAME:_____ TELEPHONE:_____

ADDRESS:_____
(Street) (City) (State) (Zip)

I hereby authorize:

_____
(Provider or Organization Name)

_____
(Address)

_____ PHONE:_____
(City) (State) (Zip)

To release a copy of medical records maintained on my behalf to:

_____
(Name of person, provider, or organization)

_____
(Address)

_____ PHONE:_____
(City) (State) (Zip)

**Information to be released** – Please **initial** next to the items you would like released:

_____ Medical Records _____ Pharmacy Records _____ Dental Records _____ Eye-Care Records

_____ Billing Records _____ Discharge Summary _____Well Child Exam/Sports Physical

_____Other: _____

Test Results: _____LAB _____ EKG _____X-RAY _____OTHER:_____

**Dates of Medical Care to be released:**_____

**Reason for release:**_____

**DISCLOSURES REQUIRING SPECIAL CONSENT:**

My **initials** below specifically authorize the release of healthcare information relating to the testing, diagnosis, or treatment for:

- ❑ HIV/AIDS Virus _____ ❑ Mental Health/Psychiatric Disorders _____
- ❑ Sexually Transmitted Diseases _____ ❑ Drug, Alcohol Abuse/Treatment _____

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA of 1996.

I hereby release Columbia Basin Health Association and its staff from all legal responsibility that may arise from the actions hereby authorized.

PATIENT'S SIGNATURE:_____ DATE:_____

PARENT OR LEGAL GUARDIAN:_____ DATE:_____

**Expiration Date (or event)** _____
If I do not indicate a date or event, this authorization will expire 90 days from the date of my signature.

CBHA Use Only:
Request Completed by:_____/date:_____ Mailed / Faxed / Hand carried:_____ / date:_____

❑ No Payment required ❑ $5/CD # of pages:_____ (x 0.25 - 1st 100 pg/0.10 add'l pgs) = _____ + Postage:_____ = _____Total

Payment/receipt received by: _____/date: _____ Payment: _____Cash Check CC