Rev 07/2019

Centricity ID:___________

COLUMBIA BASIN HEALTH ASSOCIATION
1515 E. Columbia St., Othello, WA 99344
Phone: 509-488-5256
Fax: 509-331-1601 or 509-488-9252

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:

_____Chart Notes _____Discharge Summary _____Well Child Exam/Sports Physical

_____Immunization Report _____Other:______________________

Test Results: _____All Records _____LAB _____ EKG _____X-RAY _____OTHER:________________

Dates of Medical Care to be released:________________ ❑ as needed ❑ Communication purposes only

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 authorize 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) ______________ ❑ 90 days ❑ No Expiration Date
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 ❑ Paper request # of pages: ______ x .25/pg. = ______+ Postage: ________ = ________Total

Payment/receipt received by: __________/date: __________ Payment: __________Cash Check CC