Community Health of Central Washington

Authorization to Release Patient Health Information

Patient Information (Please Print):

_____ ___/___/___

Last Name MI First Name Date of Birth

I Authorize:

Provider Name:
Facility Name:
City/ State/ Zip:
Phone/Fax:

To Release my protected health information to: (Check facility): ☐ All or specify which facility

Community health of Central Washington
Health Information Management Dept.
402 S. 12th Avenue | Yakima, WA 98902
Phone : (509)453-0722 Fax: (509)452-5224

☐ Central Washington Family Medicine- Ph:(509) 452-4520
☐ Ellensburg -Ph:(509) 962-1414
☐ Naches- Ph:(509) 653-2235
☐ Yakima Pediatrics- Ph:(509) 575-0114
☐ Highland -Ph:(509) 673-0044

Records Requested

Healthcare information related to the following treatment or condition: _____

_____

Dates of Service: ___/____/___ through ___/____/___ **or** ☐Last year ☐Last 2 years ☐Immunizations

Purpose of Release: ☐ Personal ☐ Transfer of Care ☐Continuing Care

☐ Other (Please Specify): _____

By checking the boxes below I agree to release the following:

☐ I understand that if my record contains information concerning alcohol or drug abuse/treatment, mental health (including pain management or psychiatry records) or sexually transmitted diseases (including HIV/AIDS), such information will be **INCLUDED** in this disclosure. Sensitive records require specific patient authorization if the patient is an adolescent, therefore*, we request patients over age 12 years to also authorize release of information.*

☐ I want to **EXCLUDE** the following ____ Alcohol or drug abuse treatment
____ Mental Health
____ Sexually Transmitted diseases
____ HIV (AIDS)

Patient Rights:

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when the recipient has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize to release of patient health information to the above named person or organization. Release will expire in **90 days** from the date signed.

Please sign below:

_____ _____

Signature of Patient or legally authorized individual Date

_____ _____

Printed name *(if signed on behalf of the patient)* Relationship

_____ _____

**Minor patient's signature, if applicable* Date