CVCH

Authorization to Release Medical Information

Release From:

Agency/Name:	Phone:	Fax:
Address:	City:	State/Zip:

Release To:

Agency/Name:	Phone:	Fax:
Address:	City:	State/Zip:

Purpose of Disclosure: ☐ Attorney ☐ Continuum of Care ☐ Personal ☐ Transfer of Care ☐ Testimony/ Deposition

Information to be released: (Please check **all that apply**)

☐ Billing Records ☐ Radiology ☐ Lab and Pathology Reports ☐ Medical Records ☐ Dental ☐ Immunizations

☐ All health care information (excluding sensitive information) for the last 2 years, unless specified ☐

Other_____ ☐ Date Range_____

Format: ☐ Paper ☐ Mail ☐ CD ☐ USB ☐ Transmit to Provider ☐ Communication only ☐ Other_____

This Authorization is valid for: ☐ 30 days ☐ 90 days ☐ 180 days ☐ 1 year

(If left unselected, then one year from the date of this Authorization or as required in RCW 7002030(6), whichever is shorter.)

INCLUDE the following information: ☐ HIV/AIDS diagnosis/treatment/testing ☐ Sexually Transmitted Infection

☐ Behavioral or Mental Health Service or Treatment ☐ Substance use/treatment/diagnosis/testing

Client Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or healthcare operations) and that I may revoke this authorization in writing at any time. The revocation excludes any information previously released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

I understand that my substance use disorder records are protected under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Patient full name:_____ **DOB:**_____
Address: _____
Phone: _____

Patient Signature: _____ **Print Name:** _____ **Date:** _____

Representative, Interpreter, or Witness (Please print): _____ **Date:** _____

Office Use Only (please check box) ☐ File in Chart Only ☐ Process-Send Records