Columbia Valley Community Health

Authorization to Use and Release Information

600 Orondo Ave, Ste. 1
Wenatchee, WA 98801
Ph. (509) 662-6000
Fax (509) 664-4588
1(800) 288-7649

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 ☐ Verbal Communication Only

Information to be released: (Please check **one**)

☐ The most recent pertinent information (Last several Doctor/Clinician notes, Medical History Sheet and Labs)

☐ Appointment scheduling and billing information

☐ Specific Information: _____

Method to be sent: ☐ Mail ☐ CD ☐ Transmit to Provider ☐ Communication Only ☐ Paper

This Authorization is valid for: ☐ 1 day ☐ 90 days ☐ 180 days ☐ Indefinite
(If left unselected, then one year from the date of this Authorization or as required in RCW 7002030(6), whichever is shorter.)

Exclude the Following information: ☐ Drug/alcohol abuse/treatment diagnosis ☐ HIV/AIDS diagnosis/treatment/testing
☐ Sexually Transmitted Disease ☐ Mental Illness or Psychiatric diagnosis/treatment

Client Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization at any time. 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.

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