AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize _____
To disclose health information in the medical records:

_____ BD: _____ SS#:_____
(**PRINT** name of patient)

Information to be sent to:

_____
Name of designated recipient

_____
Address

_____ _____
City, State, Zip Code Phone Number

Information to be released:

____Progress Notes ____EKG's ____Immunizations
____Lab Reports ____Problem List ____Consultations
____Radiology Reports ____Medication List ____Accounting of Disclosure
____Other (please specify) _____
____All health care information
Specify date(s) of treatment requested: _____

Purpose for which disclosure is being made: (Please check one of the following)

____Attorney ____Insurance ____ Doctor ____ Personal

Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records released (please initial)

_____Drug/Alcohol abuse/treatment & diagnosis ____Sexually Transmitted Infections
_____HIV/AIDS diagnosis/treatment/testing ____Mental Illness

My Rights
I understand I don not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign the authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health information for a third party.

I may revoke the authorization in writing. To review the process for revoking the authorization, please read the Privacy Notice to our patients. I understand that once Yakima Medical Clinic discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE _____ DATE _____
(Patient, Guardian*, or Authorized Representative*)
(Please provide documents to prove authority to sign on behalf of the patient)

This authorization will expire 90 days from the date signed. ***Possible copying fee required***
If you desire a copy of this authorization, please nifty a representative of the medical records department upon completion of this form.