

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please respond to Health Information Management

Fax: 509-575-8685 Phone: 509-575-8082

(Please provide photo ID)

Patient Name: _____ Prior Name: _____

Date of Birth: _____ Medical Record: _____

I authorize: _____ or _____

Yakima Valley Memorial
15W Yakima Ave Suite 200
Yakima, WA 98902

Hospital, physician, program, agency

Address

to release my confidential records to:

Self, Hospital, physician, program, agency

Address, Phone or Fax

- Purpose of the request:** Ongoing care/treatment Personal records
 To aid in court case Insurance

Dates of treatment: (from) _____ **(to)** _____

THIS REQUEST AND AUTHORIZATION APPLIES TO

All of the following (or mark individual boxes for only specific information to be released)

- | | | |
|---|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Report of Surgery | <input type="checkbox"/> X-Ray Reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> EKG Reports |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Emergency Dept. Record | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-ray CD | <input type="checkbox"/> Bills |
| <input type="checkbox"/> Other: _____ | | |

Includes

Excludes

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or alcohol abuse diagnosis/treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental Health records |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV or AIDS testing/treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Confirmed sexually transmitted disease (STD) |

This authorization will automatically expire after 90 days or on this date specified: _____.

You may revoke this authorization at any time by notifying the Health Information Management Department in writing. Revocation of this authorization cannot be retroactive to a release of information made in good faith. I understand that once the health information I have authorized to be disclose reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

We will not withhold treatment if you do not sign this authorization. There is a potential that the recipient as described above could redisclose your protected health information.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. Portions that I did not understand have been explained to me.

Patient or legal representative

Date and Time

Authority to sign, if not the patient

Witness

FIN

OM OD MRN
ATN

Authorization to Release
Protected Health Information
Rev. 12-16 Form 66



RI0001

3/12/2021