Columbia Medical Associates

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Tel: (509) 688-6700 Fax: (509) 489-4572

Authorization to Disclose (Release) Health Care Information

Patient name: _____ Date of birth: _____

Phone Number_____Columbia Medical Provider: _____

1. **Information to Be <u>Released From</u> (Select only one):**

   ☐ Columbia Medical Associates
   ☐ Organization, Physician, or Provider
   Name:_____
   Address:_____
   City: _____ State: _____ZipCode:_____
   Phone: _____ Fax:_____

2. **Information to be <u>Release to</u>:**

   Name:_____
   Address:_____
   City: _____ State: _____ZipCode:_____
   Phone: _____ Fax:_____

   ☐ 2 Way Verbal Communication between above named providers or persons.

3. **You may use or disclose the following health care information:**

   ☐ All health care information in my medical record (Includes 2 year history of records is sent when transferring care)
   ☐ Health care information relating to the following treatment or condition: _____
   ☐ Health care information for the following date(s): _____thru_____
   ☐ Other:_____

4. **Uses and Disclosures Requiring Specific Authorization (**By checking these boxes I **exclude** this information**):**
   ☐ **HIV** (AIDS virus)
   ☐ **Sexually transmitted diseases**
   ☐ **Psychiatric disorders/mental health**
   ☐ **Drug and/or alcohol use**
   ☐ **Reproductive Care (minors only)**

5. **Reason(s) for this authorization (check all that apply):** ☐Transfer to New Provider ☐Legal ☐Research ☐Personal use ☐Other (specify) _____

This authorization ends: ☐ on the following date: _____ or, ☐ when the following events occurs: _____
*******If neither of the above is checked, this request will expire in 90 days from the date of signature***

My Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Columbia Medical Associates based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Ways to revoke this authorization are to write a letter to Columbia Medical Associates. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature Date

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

Please supply records on: ☐ Paper ☐ CD (charges may apply per WA state Copying Fee Schedule) ☐Electronic