

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please respond to Health Information Management

Fax: 509-575-8685

Phone: 509-575-8082

Patient Name: _____ Prior Name: _____

Date of Birth: _____ Medical Record: _____

I authorize: **Yakima Valley Memorial Hospital** or _____
2811 Tieton Drive *Hospital, physician, program, agency*
Yakima, WA 98902

Address

to release my confidential records to:

Self, Hospital, physician, program, agency

Address

Reason for Disclosure _____

THE SPECIFIC INFORMATION TO BE RELEASED:

Dates of treatment: (from) _____ **(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 Operation | <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"/> 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 Medical Records Department in writing.
Revocation of this authorization cannot be retroactive to a release of information made in good faith.*

We will not withhold treatment if you do not sign this authorization. There is a potential that the recipient as described above could disclose 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

Authorization to Release
Protected Health
Information

Rev. 4-09 Form 0066

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