AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Please provide photo ID)

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**
2811 Tieton Drive
Yakima, WA 98902

or _____
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)

❑ Discharge Summary	❑ Report of Surgery	❑ X-Ray Reports
❑ History & Physical	❑ Pathology Report	❑ EKG Reports
❑ Consultations	❑ Emergency Dept. Record	❑ Lab Reports
❑ Progress Notes	❑ X-ray CD	❑ Bills

❑ Other: _____

Includes	Excludes	
❑	❑	Drug or alcohol abuse diagnosis/treatment
❑	❑	Mental Health records
❑	❑	HIV or AIDS testing/treatment
❑	❑	Confirmed sexuallly 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

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ADM

ATN

Authorization to Release Protected Health Information
Rev. 09-15 Form 0066

MEMORIAL | Yakima Valley Memorial Hospital

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