Lewis County Hospital District #1
Arbor Health
Po Box 1138/521 Adams Ave
Morton, WA 98356
Medical Records Department Phone: 360-496-3545 & Fax: 360-496-3543

RELEASE OF INFORMATION -AUTHORIZATION TO RELEASE MEDICAL RECORDS

This authorization is used to permit Arbor Health, authorization to use or disclose your individual protected health information. **Please read and complete this form in its entirety before signing.**

PATIENT INFORMATION

Today's Date:		Date of Birth:
Patient's Full Name:		
Address:		Phone #:
City:	State:	Zip:

RELEASE TO: I authorize Arbor Health to release the information specified below to :

Release To (Organization's Name):			
Address:	City:	State:	Zip:
Phone:	Fax:	Email Address:	

The individual signing this form agrees and acknowledges the following:

(1) Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility of benefits, if applicable, will not be a condition upon my signing this authorization form.

(2) Effective Time Period: This authorization shall be in effect for 180 days unless an expiration date is included:

Expiration Date: _____

(3) Right to Revoke: I understand that I have the right to revoke this authorization at any time by contacting Arbor Health's Medical Record department at the number listed above, except in the extent that the action has already been taken based on this or a prior authorization.

(4) Special Records: This authorization may include disclosure of information relating to DRUGS, ALCOHOL, SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, CONFIDENTIAL HIV/AIDS RELATED INFORMATION and GENETIC INFORMATION only if I place my initials on the appropriate line(s) under "Special Records." In the event the health information described above includes any of these records/information, and I initial the corresponding lines under the Special Records section, I specifically authorize release of such information to the person or entity indicated herein.

(5) Delivery Method: All Records will be faxed unless specified below. Identification will be required if you are picking up your records. If records are not picked up timely (3 business days), they will be destroyed.

[ ] I will be picking my records up at: (**circle one**) Arbor Health-Morton Hsp, Randle clinic or Mossyrock clinic. If nothing circled, they will be available at Morton Hospital.

[ ] Email records securely to: _____

[ ] Mail records to the organization listed above

SPECIFIC INFORMATION TO BE DISCLOSED

[ ] Medical Records from date of service: _____to date of service:_____

[ ] Location(s) of Service:_____

[ ] Laboratory Services [ ] Radiology [ ] Emergency Services [ ] Outpatient services

[ ] Entire Medical Record including patient history, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consultations, billing records, insurance records and records received from health care providers.

I have read this form and agree to the use and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SPECIAL RECORDS-PLEASE NOTE: If you would like any of the following records to be sent, you MUST also initial the items below in order for us to disclose these records.

_____ Chemical Dependency (CD) Records (42 CFR Part 2)
_____ Mental Health Records (RCW 70.02.230 or 240) (excludes psychotherapy notes)
_____ HIV/AIDs Information including HIV/AIDs test results (RCW 70.02.220)
_____ Genetic Information including genetic test results
_____ Other (please specify)_____

REASON FOR DISCLOSURE

_____ Treatment/Continuing Medical Care
_____ Personal Use
_____ Billing of Claims
_____ Insurance
_____ Other (please specify in box below)

_____ Legal Purposes
_____ Disability Determination
_____ School
_____ Employment

REQUIRED SIGNATURES

Print Patient's Full Name:

Signature of Patient: Date Signed:

If the patient is a minor or unable to sign this form, please indicate the full name and signature of the person authorized by law to sign on behalf of the patient listed above.

Print full name of authorized representative:

Signature of authorized representative: Date Signed:

Relationship to the patient: [ ] Parent of Minor [ ] Legal Guardian [ ] Personal Representative

The information above was confirmed and reviewed by (indicate below):

Arbor Health Employee: Print Full Name:

Arbor Health Employee Signature: Date: