



723 Memorial Street

Prosser, WA 99350

Also, serving PMH; Family Medicine Prosser & Benton City, Surgical Group, Physical Therapy & Rehab and Occupational Health Clinics.

Authorization to Obtain or Disclose Health Care Information

Contact Information: Phone #: 509-786-6663 Fax #: 509-786-2349

Patient Name: _____

Date of Birth: _____

Previous Name: _____

Phone #: _____

<u>Release records from:</u>		<u>Release records to:</u>	
Facility/Name: _____	Facility/Name: _____	Facility/Name: _____	Facility/Name: _____
Address: _____	Address: _____	Address: _____	Address: _____
Phone #: _____	Phone #: _____	Phone #: _____	Phone #: _____
Fax #: _____	Fax #: _____	Fax #: _____	Fax #: _____

You may disclose the following health care information:

- Diagnostic Imaging and Reports on CD (fee may apply).
- Two years of health care information in my record up to and including the most recent dates of service.
- Health care information in my record relating to the following treatment and/or dates of service:

Release my records in the following format:

- Paper Electronic (media, flash drive, CD) My Chart (maximum file size to release is 1.0 GB)
- Mail Pick up by the following individual: _____

Do NOT send records regarding (check any that apply):

- HIV/AIDS Sexually Transmitted Diseases
- Psychiatric Disorders/Mental Health Drug and/or Alcohol Use

Reason(s) for this authorization (check all that apply):

- Patient Personal Use (a fee may apply) Transfer of Care / Continuity of Care
- Legal (a fee may apply) Insurance
- Other: _____



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This authorization will automatically end 90 days after the date it is signed, unless an earlier date is specified below:

This authorization ends: _____

Patient Rights

I understand that I may not be able to revoke this authorization if its purpose was to obtain insurance. Otherwise, I may revoke this authorization at any time. Revoking this authorization will not affect any actions already taken by PMH Medical Center. I may revoke this authorization by:

- 1) Filling out a revocation form, or
- 2) Writing a letter to notify the Health Information Management Department at PMH Medical Center.

I understand that if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal and state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information

Patient signature (or legally authorized individual)

Date

Printed name (if signed on behalf of the patient)

Relationship to patient

FOR OFFICE USE ONLY

<input type="checkbox"/> Driver's License # _____	MRN: _____
<input type="checkbox"/> Other: _____	Date of Release: _____
	ID Verified by: _____