



888 SWIFT BOULEVARD
RICHLAND, WASHINGTON 99352

Health Information Management: 509-942-2017

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT INFORMATION:

Patient Name: _____ Phone number: _____ Date of Birth: _____

SSN: _____ Previous Name: (if any) _____

I request and authorize the use or disclosure of the above named individual's health information as described below.

INFORMATION TO BE RELEASED TO:

I request and authorize Kadlec Medical Center, Richland, Washington, to release health care information of the above named patient to:

Name of Organization/Person: _____

Address: _____

Purpose or need for this information is (circle one): *Medical* *Legal* *Insurance* *Personal* *Other:* _____

TYPE OF INFORMATION TO BE RELEASED:

1. GENERAL RELEASE: (this will be limited to two (2) years of information unless otherwise stated)

TYPE OF RECORD

DATES OF TREATMENT

- All Medical Records – Excluding Protected Records
- Discharge Summary _____
- Lab Results (specify) _____
- History & Physical _____
- X-Ray Reports _____
- Operative Report _____
- Consultation Report _____
- Other Reports (specify) _____

- From _____ To _____
- From _____ To _____
- From _____ To _____
- From _____ To _____
- From _____ To _____
- From _____ To _____
- From _____ To _____
- From _____ To _____

2. INFORMATION PROTECTED BY STATE/FEDERAL LAW:

- Chemical Dependency Diagnosis/Treatment*
- Alcoholism Diagnosis/Treatment*
- Mental Health Diagnosis/Treatment*
(includes Psychiatric and Psychological Evaluation)
- Sexually Transmitted Disease Diagnosis/Treatment*
(includes AIDS/HIV testing)

- From _____ To _____
- From _____ To _____
- From _____ To _____
- From _____ To _____

* Please see reverse for further information





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I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department of Kadlec Medical Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 90 days from the date signed below. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Director.

Signature of Patient or Legal Representative

Date

Relationship to Patient if not Patient

Check here if OK to fax patient information to fax number: _____

Due to confidentiality concerns, we are reluctant to fax your medical information for the following reasons:

1. If the number we are faxing to does not have a dedicated fax line, it is possible people other than those you intended will be reviewing your records.
2. There is the possibility of a misdialed number, which means your chart information can be reviewed by the public. We do have a cover letter requesting that people who have received your record in error to notify us immediately and to discard the information.

I have read and understand KMC concerns regarding faxing (please initial) _____

***DRUG AND ALCOHOL ABUSE TREATMENT INFORMATION:**

Federal regulations (42 CFR part 2) prohibit any further disclosure of this information except with specific written consent of the person to whom the information pertains or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by federal law. A general authorization for the release of information is NOT sufficient for this purpose.

***MENTAL ILLNESS INFORMATION:
(See RCW 71.05.390 through RCW 71.05.440.)**

State law prohibits any further disclosure of mental illness information without specific written consent of the person to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by State Law. A general authorization to release information is NOT sufficient for this purpose.

***SEXUALLY TRANSMITTED DISEASE INFORMATION: (Includes HIV/AIDS)
(See RCW 70.24.105 and WAC 248-100-016)**

State law prohibits any further disclosure of this information without specific written consent of the person to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by state law. A general authorization to release information is NOT sufficient for this purpose.

CONSENT OF MINOR (age 14 and above for Drug and Alcohol, and Sexually Transmitted Disease information, including HIV/AIDS; 13 and above for Mental Health Information)

A minor patient's signature is required in order to release information concerning care for:

1. Pregnancy termination and sexually transmitted diseases
2. Alcohol or drug abuse
3. Mental health conditions

OFFICE USE ONLY:	Staff Signature and
Witness: _____	_____
MRN: _____	ID verified by: [] Current patient [] Driver's License [] Other



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ADDITIONAL INFORMATION REGARDING YOUR REQUEST

Dear Patient:

Kadlec Medical Center provides the searching, copying and billing for release of information requests. If charges occur, please make checks payable to Kadlec Medical Center.

If the requester is the patient, the charge will be for actual costs of copying, postage and preparing the summary explanation at **\$.91 per page up to 30 pages, and \$.69 for additional pages after 30**. No charges will be applied at 30 pages or less for requests of pertinent information within the last 2 years.

For requests from parties **other than the patient**, the schedule of charges in compliance with the Washington State Uniform Health Care Information Act, RCW 70.02, Section 102(12) will be used:

\$21.00 Clerical fee for search and handling of records
PLUS
\$.91 per page for the first 30 pages (each)
\$.69 per page for each page thereafter

I have read and understand the above. I have enclosed prepayment for the copying of my records. I understand my records will be copied and mailed within 14 working days upon receipt of payment. I will be notified if there are circumstances affecting timeliness.

Signature of Requester/Patient

Date

Thank you,

KMC Health Information Management