Authorization to Disclose

(Release) Health Care Information

PATIENT INFORMATION:

PRINT Patient name _____

Adress_____

City, State, Zip_____

Daytime Telephone Number_____

INFORMATION TO BE RELEASED FROM:

Organization, Physician, or provider _____

Address_____

City, State, Zip_____

Phone_____Fax_____

INFORMATION TO BE RELEASED TO:

Organization, Physician, or provider _____

Address_____

City, State, Zip_____

Phone_____Fax_____

PURPOSE OF RELEASE:

☐ LEGAL ☐ INSURANCE ☐ DOCTOR ☐ MEDICAL LEAVE ☐ COPIES FOR PERSONAL USE☐ OTHER (specify)

_____

RECORDS TO BE RELEASED:

☐ Medical Records from date (YOU MUST INDICATE DATES): ___/___/_____ to date: ___/___/_____

☐ Specific Information (please specify):_____

☐ Billing Records (please specify):_____

☐ Diagnostic Images (please specify):_____

☐ Mental Health (please specify):_____

PATIENT AUTHORIZATION: I understand that:

- Information released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness and for patients age 13-17, information regarding reproductive care. I give my specific authorization for this information to be released.
- I may revoke this authorization in writing. If I revoke my authorization, it will not affect any actions already taken based upon this authorization.
- Once disclosed, health care information may be subject to re-disclosure by the recipient and may no longer be protected under health information privacy laws

SIGNATURE: DATE: _____Date____/____/_____

(Patient or Member, Guardian*, or Authorized Representative*). [*Documentation may be required to prove authority to sign on behalf of the patient.]

MINOR SIGNATURE: _____ Date___/____/_____

Signature of minor ages 13-17 is required for certain information.

This authorization expires 90 days from the date signed OR on the date or event indicated here: _____

DELIVERY PREFERENCE: _____Paper _____Disk *this option is only available to patients) **Mailed** _____ **picked up at Facility**_____.

Charge may apply-- Steck Medical patients and members can directly view and print some of their health information through their Electronic Health Record (EHR portal account. **NOTE**-The online record does not include certain scanned hospital records, behavioral health records, historical or care you have gotten from providers who do not work at a Steck Medial Group. There is **no charge** if you have the copies sent directly to a health care facility or provider for continuing or transfer of care. Copies requested by other parties may be **subject to a charge** in accordance with Washington state law (WAC 246-08-400). Contact the appropriate department listed below to request your copies of your medical record, for information about charges and/or questions related to copying health information from your Steck Medical Group medical record.

SMG Medical records Department:

1299 Bishop Rd Chehalis, WA 98532. Phone (360)748-0211 ext. 1232 - Fax (360) 262-3679