



Snoqualmie Valley
 HOSPITAL
 Dedicated to quality. Devoted to community.

**AUTHORIZATION FOR DISCLOSURE OF
 HEALTHCARE INFORMATION**

Please Print

✓
 Full Name (include middle initial)
 ✓
 Previous name if applicable
 ✓
 Date of Birth and consumer number
 ✓
 Daytime Phone number

I HEREBY REQUEST AND AUTHORIZE THE FOLLOWING EXCHANGE/RELEASE OF INFORMATION

INFORMATION TO BE RELEASED BY:	INFORMATION TO BE RELEASED TO:
Organization:	Organization: Snoqualmie Ridge Medical Clinic
Address:	Address: 35020 Southeast Kinsey Street
Address:	Address Snoqualmie, WA 98065
Phone: Fax:	Phone: (425) 396-7682 Fax: (425) 396-7694
PURPOSE OF DISCLOSURE: Continuing Care Legal Insurance At Patient Request Other: (explain)	

WRITTEN INFORMATION TO BE DISCLOSED:

Dates: From ___ To ___

Clinic Records _____
 Hospitalization Records _____
 Radiology Reports _____
 Radiology Films/CD _____
 Lab Records _____

Home Care Records _____
 Skilled Nursing Facility Records _____
 Surgery Reports _____
 Other _____

RELEASE REQUIRING SPECIFIC CONSENT:

My initials and signature below authorize the release of healthcare information relating to testing, diagnosis or treatment for:
 HIV/AIDS _____ Mental Health _____ Sexually Transmitted Diseases _____ Alcohol/Drug Abuse _____
 Reproductive Care (minors only) _____

MINORS – A minor patient’s signature is required in order to release the following information (1) conditions relating to the minor’s reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older. (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

✓ _____ ✓ _____
 Date: Signature of patient or patient’s authorized representative Relationship to patient (if not patient)
 check if patient is a minor

Witness: _____

Authorization will automatically expire 90 days from the date of my signature. I hereby release Snoqualmie Valley Hospital from all legal responsibilities or liability that may arise from disclosure of medical records in reliance upon this Authorization. Federal and State Laws protect the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a healthcare provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected in certain situations.

Revocation: This authorization may be revoked at any time by submitting a written request to:
 (Note – current revocation does not apply to information already disclosed)

**Snoqualmie Valley Hospital
 Medical Records Department
 9801 Frontier Avenue SE
 Snoqualmie, WA 98065**