Snoqualmie Valley Health

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 Valley Hospital**
Address:	**Address: 9801 Frontier Avenue SE**
Address:	**Address Snoqualmie, WA 98065**
Phone: **Fax:**	**Phone: Phone: (425) 831-2313** **Fax: (425) 831-2361**

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: _____

SIGNATURE CONFIRMING INFORMATION WAS RECEIVED:

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

Registration Staff Initials: _____

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 Health Medical Records Department
9801 Frontier Avenue SE, Snoqualmie, WA 98065