Authorization for Disclosure of Healthcare Information

Snoqualmie Valley Health

I hereby request and authorize the following exchange/release of information.

Please Print

Full Name (include middle initial): _____

Previous Name if Applicable: _____

Date of Birth and Medical Record Number (MRN): _____

Daytime Phone Number: _____

Information to be Released To

Organization: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Email: _____

Information to be Released By

Organization: Snoqualmie Valley Health

Address: 9801 Frontier Ave. SE

City, State, Zip: Snoqualmie, WA 98065

Phone: 866.984.1399

Fax: 678.669.9756

Email: snoqualmiehealth@verisma.com

Purpose of Disclosure: Continuing Care and Patient Request

Written Information to be Disclosed

Date From: _____ Date To: _____

Clinic Records _____
Hospital Records _____
Radiology Reports _____
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)

_____ Date
_____ Patient Signature or Authorized Patient Representative. *Check if patient is a minor.*
_____ Relationship to Patient *If not patient*

Witness Signature _____

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).

Signature Confirming Information Was Received

_____ Date
_____ Patient Signature or Authorized Patient Representative *Check if patient is a minor*
_____ Relationship to Patient *If not patient*

Registration Staff Initials _____

Authorization will automatically expire 90 days from the date of my signature. I hereby release Snoqualmie Valley Health 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: **Snoqualmie Valley Health, Medical Records Department, 9801 Frontier Avenue SE, Snoqualmie, WA 98065**. *Note - current revocation does not apply to information already disclosed*