



**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:	
<b>Organization:</b> Snoqualmie Valley Hospital		<b>Organization</b>	
<b>Address:</b> 9801 Frontier Ave SE		<b>Address:</b>	
<b>City, State:</b> Snoqualmie, WA 98065		<b>City, State:</b>	
<b>Medical Records Contact Information</b> <b>Phone:</b> 425-620-8750 <b>Fax:</b> 678-669-9756 <b>Email:</b> <a href="mailto:snoqualmiehealth@verisma.com">snoqualmiehealth@verisma.com</a>			
<b>PURPOSE OF DISCLOSURE:</b> Continuing Care and Patient Request			

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) _____		
<small>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).</small>		
<input checked="" type="checkbox"/> _____ <b>Date:</b>	<input checked="" type="checkbox"/> _____ <b>Signature of patient or patient’s authorized representative</b> check if patient is a minor	_____ <b>Relationship to patient (if not patient)</b>
Witness: _____		
SIGNATURE CONFIRMING INFORMATION WAS RECEIVED		
_____ <b>Date:</b>	_____ <b>Signature of patient or patient’s authorized representative</b> check if patient is a minor	_____ <b>Relationship to patient (if not patient)</b>
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 Hospital**  
**Medical Records Department**  
**9801 Frontier Avenue SE**  
**Snoqualmie, WA 98065**