AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient's PRINTED Name:	Birth date:	Home Phone Number: ( )

I hereby authorize Tri-State Memorial Hospital and Medical Campus to disclose records obtained in the course of my evaluation and/or treatment to: (Name and address of person or organization to which disclosure is to be made)

Name: **Address:**

Phone Number : ( ) **Fax Number:** ( )

Records requested-Description:	**Date(s)/ Specific provider or Clinic**		**Date(s)/ Specific provider or Clinic**		**Date(s)/ Specific provider or Clinic**
[ ] **Office Notes, Discharge Summary, History & Physical, Emergency Room, Consultations, Operative Notes, Diagnostics** No charge for first request of above records to patient or for continuation of care. Patient request for the same information within 12 month period will incur a charge of $6.50 ***Transfer of care and personal requests will include the last 2 years of the above, unless date range specified in Date(s) fields**		[ ]* **Entire record $6.50 (all documents in the medical record** **Description:** [ ] Discharge Summary [ ] Emergency Records [ ] History and Physical [ ] Consult Report(s) [ ] Operative Report(s) [ ] Rehab Services [ ] Lab [ ] Records from other providers: _____ Name(s)		[ ] Imaging/Radiology [ ] Nursing Notes [ ] Medication Record [ ] Psychiatric Report [ ] Progress Notes/Office Notes [ ] Physician Orders [ ] Pathology Report [ ] Face Sheet [ ] Other_____ [ ] Radiology images on CD [ ] **Billing Records**	

Unless otherwise indicated, I authorize the release of information regarding testing, treatment and diagnosis, to include: alcohol and drug abuse, sexually transmitted infections, HIV/AIDS, genetics and mental/behavioral health, to include psychotherapy notes. Requests for release of mental/behavioral health specific visits, to include psychotherapy notes, must be approved by the treating provider, prior to release.

_____**(initials) DO NOT INCLUDE THE ABOVE SENSITIVE RECORDS IN THIS RELEASE.**

*This section requires completion only when the request is for release to a person or entity other than the patient or legal representative (Healthcare Power of Attorney, legal guardian, healthcare representative listed in an Advance Directive).

List the purpose(s) for the release or disclosure of Protected Health Information:_____

This authorization is valid until _____ OR when the following event occurs: _____. If left blank, this authorization shall become invalid and expire 180 days after date signed.

I understand that :

1. Information disclosed by this authorization may be re-disclosed by the recipient of your records. Such re-disclosure will no longer be protected by this authorization. Federal or State laws may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.
2. I have the right to receive a copy of this authorization and there may be a charge for the medical records.
3. A copy or facsimile (fax) of this authorization **is** as valid as the original.
4. TSMH may not condition treatment, payment, enrollment or eligibility for benefits if I choose not to sign this form..
5. I may revoke this authorization in writing, at any time. The only exception is when TSMH has taken action in reliance on this authorization or the Authorization was obtained as a condition of insurance coverage.

I hereby release Tri-State Memorial Hospital from any and all legal liability and injuries that may arise from the release of this information to the party named above. The information that I am requesting may be sent by U.S. mail service, electronic facsimile and/or secure email, in accordance with the facility's policies.

I have read the above or have had it read to me and I authorize the disclosure of the Protected Health Information as stated.

SIGNED:_____ DATE: _____

(Signature of Patient/Legal Guardian or Representative*)

If signed by other than patient, indicate relationship: _____

**Authorized representative must submit copies of legal documents supporting his or her authority to act on the patient's behalf.*

OFFICE USE ONLY:

ID verified (print name and initial):_____Completed by: _____ Date Completed: _____

ROI#_____Medical Record #:_____ # of CD's/pages_____ Charge for copies/CD_____ Sales tax_____

Tri-State Memorial Hospital 1221 Highland Ave. Clarkston, WA 99403 P 509-758-5511 F. 509-758-3566-Do not fax more than 20 pages