NVH Public Hospital District No. 4
203 South Western Avenue, Tonasket, WA 98855

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name:_____ Date of Birth: _____ Phone: _____

FROM:

_____
Name of Clinic/Organization/Provider

_____
Address (Street/PO)

_____
City, State, Zip

Phone: _____ Fax: _____

PLEASE SEND TO:

_____
Name of Person or Provider

_____
Address (Street/PO)

_____
City, State, Zip

Phone: _____ Fax: _____

Please check what kind of files you prefer:

Paper ☐
Electronic Media ☐

Information to be released:

☐ Medical records for the dates ranging from:_____ to:_____
☐ Medical records relating to the following treatment/condition:
_____
☐ Billing statements dates _____
☐ Other (e.g. X-rays, labs):_____

The following items must be initialed to be **EXCLUDED** from use and/or disclosure of other health information:

_____ HIV/AIDS/STD related info
_____ Drug and/or alcohol info
_____ Psychiatric disorders/mental health
_____ Genetic testing info

Reason for the release:

☐ Personal ☐ Doctor ☐ Legal ☐ Insurance ☐ Other_____

Patient Rights

I understand that **there may be a fee/charge for record retrieval** and by signing this form I agree to pay all reasonable fees/charges associated. Should such records be sent directly to another physician for continuation of care there will be no charge. We are allowed 14 days to complete request, according to Washington State guidelines.

I may revoke this authorization in writing at any time. The only exception is when action has been taken in reliance on the authorization. This consent shall remain in effect for the period reasonable needed to complete the request.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, etc)

What information was released _____

Date: _____ Released by: _____

PUBLIC HOSPITAL DISTRICT No. 4, OKANOGAN COUNTY, WASHINGTON