AUTHORIZATION TO RELEASE INFORMATION

I give Kittitas Valley Healthcare permission to ☐ release to ☐ obtain from:

Name/Organization: ______________________________

Address: ______________________________

City, State, Zip: ______________________________ Phone #/Fax#: ______________________________

The records of:

Patient Name: ______________________________ Other Names: ______________________________

Date of Birth: ______________________________ Phone: ______________________________

Information to be released:

☐ Health records relating to the following condition(s): ______________________________

☐ ER Records ☐ Lab/EKG ☐ History & Physical ☐ Discharge Summary ☐ Operative Report

☐ Imaging ☐ Other ______________________________

Reason for release of records:
☐Transfer of Care ☐Provider Request ☐Patient Request ☐Other: ______________________________

Please EXCLUDE the following information from this request. Please check those that apply.

☐ Drug/Alcohol abuse/treatment ☐ Sexually transmitted diseases

☐ HIV/AIDS diagnosis/treatment/testing ☐ Mental Illness or Psychiatric diagnosis/treatment

I understand that KVH may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may revoke this authorization in writing at any time, except to the extent that action has already been taken. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

______________________________ ______________________________ ______________________________
Signature of Patient OR Legally Responsible party **Relationship** **DATE**

This authorization expires 90 days from the date signed or on the following day/event:

ONE COPY OF THIS AUTHORIZATION MUST BE PROVIDED TO THE PATIENT

AUTHORIZATION TO RELEASE HEALTH INFORMATION

HIM-02 (10/17)

PATIENT NAME:

DOB:

FIN: