SKAGIT REGIONAL HEALTH
SKAGIT VALLEY HOSPITAL
SKAGIT REGIONAL CLINICS
CASCADE SKAGIT HEALTH ALLIANCE

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Previous Name(s): _____

I request and authorize ❑ SVH ❑ SRC ❑ Other: _____
to release health care information of the patient named above to:

Name: _____

Address: _____

City, State: _____ Zip Code: _____

Phone: _____ Fax: _____

For the purpose of: ❑ Continuation of care ❑ Insurance ❑ Legal ❑ Personal

Information to be released:

- ❑ The most recent 2 years of pertinent information (Chart notes, labs, x-rays and special tests)
- ❑ All medical records
- ❑ Labs and/or diagnostic reports
- ❑ Specific information (list condition or dates): _____

Release format: ❑ Paper ❑ Electronic

Patient authorization: *I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.*

EXCLUDE the following information from the records to be released (please initial as appropriate):

_____ **Drug/alcohol abuse treatment/diagnosis** _____ **Sexually Transmitted Disease**
_____ **HIV/AIDS diagnosis/treatment/testing** _____ **Mental illness or psychiatric diagnosis/treatment**

Minors: If patient has reached his/her 13th birthday, only the patient may authorize the disclosure of information relating to mental health, alcoholism or drug abuse. If patient has reached his/her 14th birthday, only the patient may authorize the disclosure of information relating to sexually transmitted diseases (including HIV/AIDS). A patient of any age may authorize the disclosure of information relating to pregnancy, pregnancy termination, birth control or sterilization.

My rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I am entitled to a copy of the authorization and I may revoke this authorization in writing. 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, Guardian, or Authorized Representative Date
(Please provide documents to prove authority to sign on behalf of patient)

Relationship to patient, if other than patient : _____

This authorization will expire 90 days from the date signed or on: _____

SRH will provide complimentary copies of your healthcare information to your provider.

All other requests are subject to a fee. Please inquire about charges.

INTERNAL USE ONLY:
MRN# _____
Date Received: _____
Date Processed: _____
Processed by: _____
Released by: _____

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SC11
11/22/2013