**SKAGIT REGIONAL HEALTH**
SKAGIT VALLEY HOSPITAL
SKAGIT REGIONAL CLINICS
CASCADE VALLEY HOSPITAL

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH CARE INFORMATION

Patient Label

Skagit Regional Health: PH# 360-814-8462 — 1415 E. Kincaid Street, Mount Vernon, WA. 98273
Including: Skagit Regional Clinics — 1400 E. Kincaid Street, Mount Vernon, WA. 98274
Cascade Valley Hospital — 300 S. Stillaguarnish Ave., Arlington, WA. 98223

**1. Patient Information**

| | |
|---|---|
| Name (First, Middle, Last) | (Maiden or any previous last names) |
| Current Address | City State Zip Code |
| Date of Birth | Phone Number |

I understand that the health information authorized for release with this form may include sexually transmitted diseases; human immunodeficiency virus (**HIV**) or acquired immunodeficiency syndrome (**AIDS**) and/or information relating to diagnosis or treatment of mental health; substance abuse and that to sign here specifically refuses authorization to release records pertaining to the following:

- ☐ Substance Abuse (including alcohol/drug abuse)
- ☐ Mental Health
- ☐ Sexually Transmitted Diseases (including HIV, AIDS related testing)

The confidentiality of this record is required under **Title 42 CFR, part 2, of the United States Code**. These Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or authorization as provided in this statute.

_____

**Signature of Patient, Legal Guardian or Authorized Representative** **Date**

**2. Release (disclose) information to:**

| | |
|---|---|
| Name of Recipient | Phone Number |
| Address | Fax Number |
| City State Zip Code | E-mail address |

**Requesting Information from:**

| | |
|---|---|
| Name of Recipient | Phone Number |
| Address | Fax Number |
| City State Zip Code | E-mail address |

**Release Format:** ☐ **Paper** ☐ **Electronic (CD, Patient Portal)**

SC11
12/2018

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**Check box(s) below for service type, description and date of service:**

| | Description and | Date of Service |
|---|---|---|
| | Discharge Summary | |
| | History and Physical | |
| | Emergency Dept. Record | |
| | Laboratory Report | |
| | Operative Report | |
| | Office Note | |
| | Immunizations | |

| | Description and | Date of Service |
|---|---|---|
| | Inpatient Record | |
| | Outpatient Record | |
| | Radiology Report | |
| | Imaging | |
| | EKG | |
| | Other: | |
| | | |

**3. Minors:** If patient has reached his/her 13th birthday, only the patient may authorize the disclosure of information relating to mental health, outpatient alcohol 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), inpatient alcohol or drug abuse. A patient of any age may authorize the disclosure of information relating to reproductive rights.

**4.** This authorization expires when the patient information is disclosed as permitted in this authorization, or on _____ **(Date cannot exceed one year from the date of signature below)**.

**5. I may revoke this authorization at any time.** Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released pursuant to this authorization. **Contact Medical Records c/o Skagit Valley Hospital, 1415 E. Kincaid Street, Mount Vernon, WA. 98273.**

**6.** My care or treatment will not be conditioned on signing this authorization.

**7.** The persons to whom information is disclosed under this authorization may possibly redisclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no longer be protected by law.

**8.** Skagit Regional Health and/or its copying services reserve the right to charge for processing and copying information. Patient access fee may apply for copies. Fees are authorized by the **State of Washington (RCW 70.02,010 & WAC 246-08-400)**. This fee is waived when releasing information directly to a treating physician or health care facility.

**Signature** _____ **Relationship (if other than patient):** _____
Patient, Parent of Minor, Legal Guardian, Personal Representative, Heir at Law, Person under a POA*

**Date:** _____ **Time:** _____
*If Legal Guardian, Personal Representative or person with authority under a durable medical power of attorney, please provide a copy of appropriate documentation.

**INTERNAL USE ONLY:**
**Date Received:**
**Date Processed:**
**Processed by:**
**Release by:**
☐ **SRC**
☐ **SVH**
☐ **CVH**