AUTHORIZATION TO RELEASE HEALTH INFORMATION

I. PATIENT INFORMATION

Name ____ Date of Birth _______________________

Address ____

City/State/Zip ____ Phone _______________________

II. RELEASE OF INFORMATION

☐ I authorize White Memorial Community Health Center to release information to:	☐ I authorize White Memorial Community Health Center to obtain information from:
Name	Name
Address	Address
City, State Zip	City, State Zip

Phone Fax Phone Fax

Information to be released:

- ☐ All health records
- ☐ Health records for the following dates: ____
- ☐ Health records for the following condition: ____
- ☐ Other (X-ray, billing, etc): ____

You may release information regarding testing diagnosis, and treatment for (check all that apply): ☐ HIV/AIDS virus ☐ Sexually transmitted diseases ☐ Drug and /or alcohol use ☐ Psychiatric disorders/Mental Health

Reason for the release: ☐ Personal ☐ Doctor ☐ Attorney ☐ Insurance ☐ Other ____________________________

III. PATIENT'S RIGHTS

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. If I do, it will not affect any actions already taken by White Memorial Community Health Center (WMCHC) based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I must write a letter to WMCHC. This information may be subject to redisclosure and may no longer be protected by federal or state privacy laws.

This authorization expires _________________ (if left unsigned, the 1 year from date of this authorization or as required in RCW70.02.030(6), whichever is shorter.)

Patient or legally authorized individual signature _______________________________________ Date _________________

Printed Name ____ Relationship ___________________________