SUMMIT PACIFIC
• MEDICAL CENTER •

# RELEASE OF RECORDS

600 East Main Street
Elma, WA 98541
Medical Records Fax: 360-346-2161
Medical Records Phone: 360-346-2264

SUMMIT PACIFIC MEDICAL HOSPITAL *SUMMIT PACIFIC HEALTHCARE CLINIC *ELMA FAMILY MEDICINE *MCCLEARY HEALTHCARE CLINIC

## Patient Information

**Name:** _____ **DOB:** _____

**Address:** _____ **City:** _____

**State:**_____ **Zip:** _____ **Home Phone:** _____and/or **Cell Phone:** _____

## Name of Clinic, Hospital, or Healthcare Provider – (Who has the information the patient want released?)

**Name:** _____

**Address:** _____ **City:** _____

**State:** _____ **Zip:** _____ **Phone:** _____ **Fax Phone:** _____

## Receiving Party – (Where do you want the information sent? Who may have the information?)

**Name:** _____

**Address:** _____ **City:** _____

**State:** _____ **Zip:** _____ **Phone:** _____ **Fax Phone:** _____

**Deliver Method for Request:** ☐ **PICK-UP** ☐ **MAIL** ☐ **FAX**

## Information to be Released - (What do you want sent or released?)

I understand that the protected health information (PHI) I am requesting may include disclosure of information regarding HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse or mental illness. I authorize the release or disclosure of this information unless I check the box below. Please note that this form **will not** be used to disclose psychotherapy PHI.I do **NOT** want any information relating to:

☐HIV/AIDS, ☐sexually transmitted disease, ☐ drug and/or alcohol or ☐ mental illness disclosed.

**Please release the following (check all that apply):**

☐ Clinic Records* ☐ Labs ☐ Radiology Reports/Films ☐ Hospital Records* ☐ All Medical Records
☐ Billing Records ☐ Specific Information (Specify): _____

***** SPMC will provide the patient with the past two years' worth of records unless otherwise stated below.

**Indicate date(s) of service or event** _____

## Purpose of Release – (Why is this information needed?)

☐ Transfer of Care ☐Personal Use/Review ☐Legal ☐Insurance Application ☐ Other* _____

## Consent – (Approval for Release of Records)

By signing this this Request of Information, I give my authorization for the records designated to be released as directed above.

If patient has reached his/her thirteenth (13th) birthday, and has consented to treatment, **ONLY** the patient can authorize disclosure relating to HIV/AIDS, Sexually Transmitted Diseases, Drug and/or Alcohol Abuse, Mental Illness.

I understand the following: See CFR §164.502(c)(2)(i-iii) I have a right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity that has already acted in reliance on my authorization. I understand that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Information disclosed under this authorization might be re-disclosed by the recipient, and the re-disclosure may no longer be protected by federal, state or privacy laws. The provider must make the healthcare information available within 15 working days after receiving the request or notify the patient of any delay (RCW70.02.080) I understand that I have a right to receive a copy of this authorization.

**Signature**: _____ **Relation(If not self)** _____ **Date:** _____

**(This authorization expires one year from date signed)**

☐ **ID Checked (Driver's License, Military ID, Photo ID, SS Card)** **SPMC Reception Initials:**_____ **Pick Up Date:**_____

**SPMC HIM Staff Initials:**_____ **ROI Completion Date:**_____