Spokane Regional Health District Treatment Services

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Birth Date:_____
Maiden/Prior Names:_____ Current Phone #: _____
Current Address:_____

I am requesting disclosure of my protected health information for the following purpose:

- ☐ Continuing Care
- ☐ Academic
- ☐ Disability Determination
- ☐ Legal Investigation
- ☐ Child Custody
- ☐ Other:_____

Dates of Service Requested:_____

I authorize the release of the following:

- ☐ Continuity of Care Packet -Discharge Plan Parts 1 and 2, Discharge Safety Plan, Medication Reconciliation, Advance Directives)
- ☐ History and Physical
- ☐ Alcohol and Drug Abuse Treatment Records
- ☐ Physician's Orders
- ☐ Discharge Summary
- ☐ Psychiatric Evaluation
- ☐ Lab/Diagnostic Reports
- ☐ Progress Notes
- ☐ HIV Test Results and AIDS Treatment Records
- ☐ Other:_____
- ☐ Verbal Exchange of Information

To be released by:

☐ Spokane Regional Health Treatment Services

☐ _____ (____)_____ _____

Agency/Name | Telephone Number | Address | City | State | Zip Code

To be released to:

☐ _____ (____)_____ _____

Agency/Name | Telephone Number | Address | City | State | Zip Code

(____)_____

Fax Number

This authorization will expire on ____/____/20____. (If not indicated, authorization will expire six months from signature date)

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

_____

Revocation Signature | Date/Time

This form must be completed in full before signing:

_____ _____ _____

Patient's signature (required for ages 12 and older) | Parent/Legal Guardian signature (if applicable) | Relationship to Patient

_____ _____

Witness signature/Credentials | Date Signed

This authorization is intended to allow **Spokane Regional Health Treatment Services** to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.