Cascade Family Medical Clinic

PO Box 358, Centralia, WA 98531
Phone: 360-736-7623

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

* * Expires 90 days from date below and may be revoked by the patient at any time, orally or in writing. * *

Patient Name _____ Phone _____ Date of Birth _____

Patient Address _____ Soc Sec # _____

Reason for Request: ☐ Closure of Clinic

Please provide the following records:

☐ Medical Records - past two years (Most providers only request one to two years for new patients)

☐ Medical Records from _____ to _____ (Maximum ten years)

☐ Medical Records specifically pertaining to _____

I authorize Cascade Family Medical Clinic to allow my records to be picked up by:

_____

(Name of individuals authorized to pick up my records)

Health Information to be released:

Identifies the patient by name and includes demographic information
May include, but is not limited to: medical records, x-rays, slides, tracings, strips, etc.

- After medical records are disclosed, they may be disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- Further use of disclosure of the authorized information may not be accomplished without additional written consent.
- The expiration date for information to be used for research purposes does not apply.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

By signing this form:

☐ I understand that my records may contain information regarding psychiatric/mental health diagnosis and treatment, drug and/or alcohol abuse (Per 42CFR, Part 2), the testing diagnosis, or treatment of communicable disease including HIV/AIDS and/or sexually transmitted diseases (Per RCW 70.24.105).

☐ I DO NOT want the following information to be released:

_____

Patient's Signature/Authorized Party _____ Date _____

Relationship to Patient _____

First copy medical request charges: After September 4, 2019 - $20.00
After September 16, 2019 - $25.00
After September 30, 2019 - $30.00

Second copy medical request charge: Prior to August 30, 2019 - $25.00
After August 30, 2019 - $50.00