WhidbeyHealth Medical Center
101 N. Main Street, Coupeville WA, 98239
360.678.5151 360.321.5151
www.whidbeyhealth.org

AUTHORIZATION TO **PROVIDE** HEALTH INFORMATION

WhidbeyHealth Medical Center is hereby authorized to furnish all *requested* information contained in my medical record to:

_____

(Name and address of person or organization (i.e. name of insurance co.)

Patient Name_____ Date of Birth _____ Medical Record_____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The type and amount of information to be used or disclosed is as follows: (check box and include dates where appropriate)

- ☐ most recent Procedure/Operative Report
- ☐ most recent Discharge Summary
- ☐ most recent History and Physical
- ☐ _____Clinic Records from (date)_____ to (date) _____
- ☐ Emergency Room Record…. from (date)_____ to (date) _____
- ☐ Laboratory/ Pathology…….. from (date)_____ to (date) _____
- ☐ Radiology Reports ……from (date) _____ to (date) _____
  Modality:_____ (dates)_____
- ☐ CD or Film……from (date)_____ to (date)_____
- ☐ Consultation reports…….. from (date) _____ to (date) _____
- ☐ Billing…….from (date) _____ to (date) _____
- ☐ Entire Record…….from (date) _____ to (date) _____
- ☐ Other_____

Staff to Complete on Release

Date/Time:

Initials:

Pages:

_____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. With this release you are hereby *specifically authorized to release* all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below:

_____

The above information is released for the following purpose (state purpose of disclosure, i.e. payment of insurance claim, continuation of care, etc.)

_____

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to WhidbeyHealth Medical Center's Health Information Services department.. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire ninety days after the date the authorization is signed, or later, at my election on the following date, event, or condition: _____. If I fail to specify an earlier expiration date, event, or condition, this authorization will expire in 90 days.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or receive a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact WhidbeyHealth Medical Center, Health Information Services.

_____Date_____

Signature of Patient **OR** Legal Representative

_____ _____Date_____

Relationship to Patient, if signed by legal representative Signature of Witness

INSTRUCTIONS FOR *RELEASE OF INFORMATION* FORM

To whom do you (the patient) want records to be released? If records are to be released to yourself, please put your name on the first line, and then, your name on the "Patient Name" line. (REQUIRED)

If you, as the patient, want records to be released to another person (not to yourself), please put the person's name on the first line, and your name on the "Patient Name" line. Please indicate also, on the first line, the address of the person to whom records will be released for mailing purposes. (REQUIRED)

Your date of birth is required for purposes of determining you from other patients with possibly the same name.

Your Medical Record Number is an internal number that will be added to your form later by the Medical Record staff and is not required by you.

2: This section is for you to indicate what information you want to be released from WhidbeyHealth Medical Center. If you know the dates please indicate what documents and what dates of service are to be released. If you do not know the dates of service, please indicate what illness or injury and a general time period in the "other" section. For example, lab tests done on 02/02/2008, or all records regarding a knee injury from 2001 through 2008.

3: If you have sensitive information that you would like removed from your record, please indicate that information to be removed here.

4. This is a section indicating your rights to revoke your release form if you desire, after you fill it out, but before your records are released. It also contains a section to limit the amount of time that your release form is acceptable. If you indicate a time period on the open line, your form will expire before ninety days.

5. This section is another section explaining your rights about signing the form, as well as re-disclosure. The last section is where the patient gives his/her authority for WhidbeyHealth Medical Center to release the medical records by an authorized signature. The patient, only, has authorization, unless there is a Durable Power of Attorney for Healthcare on file at WhidbeyHealth Medical Center, or the next-of-kin for a patient who has expired may sign. Patients or authorized persons must sign and date the form, and a witness must observe the signature by the patient, and sign and date the form also.

Please return your signed and filled out form to the Medical Record Department (Health Information Management). The FAX number is 360-678-7623. Or, you may mail your request: WhidbeyHealth Medical Center, Attn: HIM-Sheryl, 101 North Main Street, Coupeville, WA 98239. The turn-around time to receive your medical records is approximately two weeks. There may be a fee for the release of medical records. Additional FAX numbers: #2 360-678-7668
#3 360-678-8620
If you would like help filling out your Release of Information form, please call Health Information Services at 360-678-7656, Extension 6403.