AUTHORIZATION TO RELEASE or REQUEST HEALTHCARE INFORMATION

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Patient Legal Name:_____ **Date of birth:**_____

Former Name(s):_____ Phone #:_____

Address:_____ City:_____ State/Zip: _____

I request and authorize CASCADE MEDICAL at 817 Commercial Street, Leavenworth, WA 98826 to □***Release*** OR □***Request*** my healthcare information to the entity(s) below (if more than 2 entities please use back of form to add more):

Name:_____ Phone#:_____ Fax #: _____

Address:_____ City:_____ State/Zip: _____

Name:_____ Phone #:_____ Fax#: _____

Address:_____ City_____ State/Zip Code: _____

OR Release to Self via Mail or Lobby Pick-up (circle one) OR email: _____

Print clearly

Healthcare information to be released or requested:

Date range_____ **Types of Records:** □Emergency Room Record □Lab Reports(s) □Immunizations □Provider Office Notes □Diagnostic Images & Reports □Inpatient Records (includes Discharge Summary, History and Physical, Operative / Procedure Report(s)) □Consultations □Colonoscopy & Path □EKGs - **ALL** □PAP & Path Reports - **ALL** □PT/OT/ST □Billing Records □Other:_____

Records with special protection: State and federal laws protect certain healthcare information. I understand that unless otherwise indicated or specified here, a request for disclosure or release of healthcare information/records may include information regarding the diagnosis and/or treatment of HIV (AIDS virus), other sexually transmitted infections, drugs and/or alcohol abuse, behavioral health, mental illness or psychiatric treatment, sexual abuse or assault, domestic violence, genetic information, adoption information, social service records, communications made to a social worker.

If this information applies to you, you **must** check **YES** or **NO** if you would like this information released:

Alcohol, Drug or Substance Abuse Records	□Yes □ No
HIV/AIDS Testing and Results	□Yes □No
Mental Health, Psychotherapy Records	□Yes □No

By signing this authorization, I understand that:

- Requests for copies of medical records are subject to reproduction fees, in accordance with federal/state law. I have the right to cancel this authorization at any time. Cancellation must be made in writing and presented or mailed to Cascade Medical at 817 Commercial Street, Leavenworth, WA 98826. Cancellation will not apply to information/records already issued in response to this authorization. Cascade Medical is not responsible for any unauthorized re-disclosure of my healthcare information by others including the person or facility receiving the records requested in this authorization.
- This authorization will expire one year from the date signed unless I cancel before that time. I am not required to sign this authorization. I may have a copy of this authorization at my request. I understand the use of email is at my own risk.

Signature of patient:_____ Date: _____

Signature of patient's legal representative:_____ Date: _____

Print name: _____

Relationship to patient: _____

For CM Use ONLY
Date completed: _____
*Initials:*_____
ID Check: _____