CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name *(please print)* ____

Date of Birth ____________________________ SS# ____________________________

Address ____

City/State/Zip Code ____

Telephone Number ____

Choose A or B below:

A. **From Cascade Medical Center —**
I hereby authorize Cascade Medical Center to release a copy of my medical records to:

Provider/Agency ____

Address ____

City/State/Zip Code ____

Telephone Number ____

B. **To Cascade Medical Center —**
I hereby authorize the following healthcare provider/agency to release a copy of my medical records to Cascade Medical Center located at 817 Commercial Street, Leavenworth, WA 98826

Provider/Agency ____

Address ____

City/State/Zip Code ____

Telephone Number ____

*Please send the specific information (specify dates of service): ___________________________

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*Reason for release: ____

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I understand that records maintained on my behalf may contain information regarding the diagnosis and/or treatment of HIV (AIDS virus), other sexual transmitted diseases, drugs and/or alcohol abuse, mental illness or psychiatric treatment. I give specific authorization for these records to be released.

I hereby release Cascade Medical Center and its staff from all legal responsibilities that may arise from the act here authorized. *To be valid, this authorization must be dated within 90 (ninety) days of the request for the information and can be revoked at any time.*

Patient signature ____________________________________ Date _______________

Parent/ Legal Guardian _______________________________ Date _______________

For CMC use only: Record No. _______________ Date sent _______________ Signature ______________________