AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Patient's Name: _____ Date of birth: _____

I request and authorize CASCADE MEDICAL at 817 Commercial Street, Leavenworth, WA 98826 to release my healthcare information (as outlined below) to:

Name: _____ Phone number: _____

Address: _____ City _____ State/Zip Code _____

Healthcare information to be released:

Medical Records (specify, can say "all") _____

Billing Records (specify, can say "all") _____

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 "all" or "any" 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, 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, please indicate if you would like this information released:

- Alcohol, Drug or Substance Abuse Records ☐ Yes ☐ No Dates: _____
- HIV/AIDS Testing and Results ☐ Yes ☐ No Dates: _____
- Mental Health, Psychotherapy Records ☐ Yes ☐ No Dates: _____
- Other (specify, can say "all") _____ ☐ Yes ☐ No Dates: _____
  OR
- All past, present and future encounters/visits: ☐ Yes ☐ No

Reason for request: ☐ Legal ☐ Insurance ☐ Personal ☐ Other _____

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 redisclosure 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.

Signature of patient: _____ Date: _____

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

Print name: _____

Relationship to patient: _____

(ORIGINAL TO BE FILED IN THE PATIENT'S MEDICAL RECORD) *Version: 4/25/2018*