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): _____

_____

*Reason for release: _____

_____

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 _____