Authorization to Disclose Health Information - *Please complete both pages.*

☐ Mailed ☐ Faxed ☐ Pick-up

Expiration date: _____

Patient Name: _____ aka: _____

Date of Birth: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

I. I authorize disclosure of the following information (initial appropriate boxes below):

Initial	Record Type	Dates		Initial	Record Type	Dates	
		From	To			From	To
	Discharge Summary/Instructions/Plan				Crisis/Desert Hope		
	History and Physical/Consult				Letters/Forms		
	Office Note				Assessment/Intake/Admission Note		
	Immunization Records				Treatment attendance.Compliance		
	Emergency Room Record				Other		
	Operative Report						
	Progress Notes						
	Lab Results/Pathology/Radiology						
	Therapy Notes/Treatment Plan						
	Verbally Communicated				All Records		

II. I would like the following information **INCLUDED** in the materials disclosed (initial applicable boxes below):

___ Alcohol/Drug abuse ___ Mental Health ___ Sexually Transmitted diseases

___ Genetic Testing ___ Communicable Disease ___ Hepatitis B and/or C ___ HIV/AIDS

If any of these boxes is unchecked, the following notification applies: This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR, Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information Is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally Investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov 2, 1987]

III. I would like the information described above prepared using the following process (please check):

***There is a fee associated with the production of the records.**

☐ Photocopy ☐ Compact Disc (Radiology Images)

IV. **I understand:**

1. I may revoke this authorization in writing by delivering revocation notice to the Medical Records Director at Lourdes Health Network, at any time, except if disclosure is made to obtain payment, treatment, operation or as stated in the Notice of Privacy Practices and except to the extent that action has been taken in reliance on this authorization.
2. This authorization expires in 365 days or sooner if specified here _____
3. Protected Health Information is disclosed to those not required to comply with federal privacy protections. Such information may be re-disclosed and would no longer be protected by federal privacy protections. This facility, officers, employees and physicians are hereby released from any legal responsibility or liability for disclosure of above information to extent indicated and authorized herein.
4. I do not have to sign this authorization as a condition of receiving treatment, payment enrollment or eligibility of benefits from Lourdes Health Network.
5. I have the right to inspect and receive copies of my protected health information in accordance with the provision of the federal privacy standards. Fifteen working days are allowed to respond to requests, 21 days in difficult circumstances.
6. There may be charges associated with my request for records, which may not exceed those allowable under RCW 70.02.010.

I understand that my records are protected under Federal and/or Washington State Law and cannot be disclosed without my written consent unless otherwise provided for in the regulations including 45 C.F.R. Parts 160 and 164 (HIPAA) and 42 C.F.R. Part 2.

I understand that a general authorization is not enough to release health care information relating to the testing, diagnosis and or treatment of alcoholism/chemical dependency treatment - Federal Regulations; Mental Health/Psychiatric - RCW 71.05.390 - RCW 71.05.440; Sexual Transmitted Diseases records includes AIDS/HIV - RCW 70.24.105, and HIPAA 1996 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I do not have to sign this authorization in order to receive health care benefits (treatment, payment, enrollment, or eligibility for benefits) except for health care services necessary to create any assessment or report for disclosure to the recipient identified in this authorization.

I acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

V. I would like the information above disclosed from and to the individuals or organizations below:

✓	FROM	✓	TO
☐	Lourdes Health Network 520 N. Fourth Ave. Pasco, WA 99301	☐	Name of person or organization: _____ Street/Address _____ City, State, Zip _____ Fax _____ Phone _____
☐	Lourdes Counseling Center 1175 Carondelet Dr. Richland, WA 99354		
✓	**FROM**	✓	**TO**
☐	Name of person or organization: _____ Street/Address _____ City, State, Zip _____ Fax _____ Phone _____ E-mail address: _____	☐	Lourdes Health Network 520 N. Fourth Ave. Pasco, WA 99301
		☐	Lourdes Counseling Center 1175 Carondelet Dr. Richland, WA 99354

The purpose for this release of patient health information is (please check):

☐ Legal/personal injury ☐ Treatment or consultation
☐ Personal use ☐ Other (specify) _____

Signature of Patient/Patient's Representative: _____ Date: _____

Printed Name of Patient or Representative: _____

Witness: _____ Date: _____

(STAFF USE ONLY) Identity of Requester Verified via (Initial): Photo ID _____ Matching Signature _____ Other _____

LOURDES HEALTH

Health Information Management

Release of Protected Health Information