Mid-Valley Hospital & Clinic

509.826.1760 Hospital
509.826.1600 Clinic
mvhealth.org
PO Box 793
Omak, Washington 98841

1. Patient Information

Patient Name (Last, First MI): ______________________ Date of Birth: ____________

Former Name(s)/Alias: ______________________ Phone Number: ____________

Mailing Address: ______________ City: ____________ State: ________ Zip: ________

2. Records to be Disclosed Between:

Name: **Mid-Valley Hospital and Clinic** Address: **810 Jasmine St.** City: **Omak** State: **WA** Zip: **98841**

Name: ____________ Address: ____________ City: ____________ State: ______ Zip: ______

3. Records to be Disclosed With: *(e.g. Insurance Company, Attorney, Provider, Patient)*

☐ Attorney ☐ Insurance ☐ Provider/Transfer of Care ☐ Personal ☐ Other(specify): ____________

Name (**WHO** information may be exchanged with): ______________________

Phone Number: ____________ FAX Number: ____________ Email: ____________

Mailing Address: ______________ City: ____________ State: ________ Zip: ________

4. Purpose of Release

☐ Attorney ☐ Insurance ☐ Provider/Transfer of Care ☐ Personal ☐ Other (Specify): ____________

5. Delivery Method *(I authorize my records to be delivered in the following method)*

☐ US Mail ☐ Email ☐ Patient Portal ☐ FAX ☐ Pickup at Mid-Valley Hospital

6. Information to be Disclosed:

☐ Recent 2 years hospital & clinic (physician reports, labs, x-rays & special test)

☐ Clinic (office visit, lab radiology, medicines, immunizations)

☐ Hospital (H&P, discharge summary, consults, emergency room, lab, radiology, special tests, operative reports)

☐ Specific Information (Specify): ______________________

☐ Billing Records ☐ Radiology Reports/ Films/ Images ☐ Labs/Special Tests

INDICATE DATE(S) OF SERVICE: ______________________

7. Sensitive Health Information *(By checking a box below, you authorize the release of sensitive information)*

☐ Attorney ☐ Insurance ☐ Provider/Transfer of Care ☐ Personal ☐ Other (Specify): ____________

8. Authorization

I understand that: 1) Requests for copies of medical records subject to reproduction fees in accordance with federal/state regulations. 2) Authorization will expire 365 days from the date signed unless otherwise specified (**Other Date**: ____________). 3) I have the right to revoke this authorization at any time. Revocation must be made in writing and faxed to 509-826-7678 or mailed to PO Box 793 Omak, WA 98841. Revocation will not apply to information that has already been disclosed in response to this authorization. 4) Any disclosure of information carries with it the potential for unauthorized disclosure, and the information may not be protected by Federal confidentiality rules.

Printed Name of patient/legal representative: ______________ Relationship to patient: ____________

Signature of patient/legal representative: ______________ Date: ____________ Time: ____________

Signature of minor (age 13-17) if requesting sensitive information: ______________________

Not valid without CURRENT PHOTO ID****