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 With:

Name: **Mid-Valley Hospital and Clinic** Address: **810 Jasmine St. PO Box 793** City: **Omak** State: **WA** Zip: **98841** Fax: **(509) 826-7678**

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

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: **INDICATE DATE(S) OF SERVICE:** _____

☐ 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

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

☐ HIV/AIDS ☐ Sexually Transmitted Infections ☐ Alcohol/Drug or Substance Abuse ☐ Behavioral Health / Psychotherapy Records ☐ Other (Specify): _____

8. Authorization:

This information has been disclosed from records protected by federal confidentiality rules (42 CFR part 2 (/regulations/42/2). The federal regulations prohibit you from making any further disclosure of information in this record without the specific written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2 (/regulations/42/2). A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of this information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12 (/regulations/42/2.12) (c) (5) and 2.65 (/regulations/42/2.65). Patient protected health information (PHI) will not be used or disclosed for the purposes of investigating or imposing liability on the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care, and obtaining attestations for uses and disclosures of PHI potentially related to reproductive health care for the purposes of health oversight, law enforcement, judicial or administrative proceedings, coroners and medical examiners.

I understand that: 1) Requests for copies of medical records are 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.

Signature Name of patient/legal representative: _____ Relationship to patient: _____

Printed Name of patient/legal representative: _____ Date: _____ Time: _____

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

Not valid without CURRENT PHOTO ID****