

Tri-State Memorial Hospital
PO Box 189
Clarkston, WA 99403
(509) 758-5511 (phone)
(509) 758-3566 (fax)

Patient's Name _____
Birthdate _____
Medical Record # _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This is to authorize that medical information regarding the above identified person be forwarded by a Tri-State Hospital employee.

FROM: Tri-State Memorial Hospital
PO Box 189
Clarkston, WA 99403

TO: _____
Physician/Individual/Institution Requesting Medical Data

Street Address City State Zip Code

Fax Number Phone Number

I do not want my medical records faxed.

PURPOSE OR NEED FOR DATA: Continuing Care To pay the hospital bill
 Other _____

DATES REQUESTED: Dates of Hospitalization _____
 History and Physical Report Operative Report
 Pathology Report
 Discharge Summary
 Laboratory Reports
 X-rays Reports Films
 Other _____

I acknowledge that data to be released may include material that is protected by Federal Law and that is applicable to drug/alcohol abuse information, mental health information, sexually transmitted disease and/or HIV/AIDS information. My signature below authorizes release of all information. I acknowledge that the above information may be sent by FAX and may be received by persons other than medical personnel and consequently, there is a risk of loss of confidentiality. I understand that this information may be redisclosed by the physician or institution requesting the information and is no longer protected.

This release of information authorization is valid for 90 days and may be revoked by me, in writing, at any time. I understand that that I may revoke my authorization except to the extent that Tri-State Hospital has taken action in reliance thereon. I understand that there are ways that my health information can be disclosed without my authorization. If I would like more information on these disclosures, I understand I can request a copy of the "Notice of Privacy Practices."

Date of Request

Patient/Responsible Party

Date Authorization Expires
(90 days from Request date)

Relationship to Patient

Request denied. See "Release of Information-Response to a Patient's Request" for steps to take.

Witness