THREE RIVERS HOSPITAL PO Box 577 Brewster WA 98812
(509) 645-3395 Fax (509) 645-3311

Patient Authorization for Three Rivers Hospital to Disclose/Release Protected Health Information

Please read and complete the entire form so your request can be processed.

I authorize Three Rivers Hospital to disclose protected health information about:

_____ _____/_____/_____

Name of Patient *Birth Date (mm/dd/yyyy)*

for health care provided beginning _____/_____/_____ **and ending** _____/_____/_____ **.**

Date (mm/dd/yyyy) *Date (mm/dd/yyyy)*

The purpose of the disclosure is for:

- ❑ Billing Insurance Company or third party payer
- ❑ Information requested for legal process (i.e. subpoena or court order)
- ❑ Continuing medical care outside of Three Rivers Hospital
- ❑ Other; Specify _____

Expiration Authorization:

This authorization expires on _____(Date) **OR** when the following event occurs: _____

(State when Three Rivers Hospital is no longer authorized to disclose my information based on this authorization).

If an expiration date is not provided, this authorization will expire one year from the date this Authorization Form was signed.

Note: Authorizations to disclose your information to an employer or financial institution can only be effective for a maximum of 90 days from the date signed by you.

Information to be disclosed:

- ❑ Laboratory/Diagnostic Tests
- ❑ Discharge Summary
- ❑ Consultation
- ❑ EKG Report
- ❑ Pathology Report
- ❑ Radiology Report
- ❑ Radiology Image
- ❑ Operative Report
- ❑ Billing
- ❑ All Records
- ❑ Other (please specify) _____

I authorize sensitive information about my conditions which may include sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include sensitive information about behavioral or mental health services and treatment for alcohol and drug abuse.

If I choose to not authorize the sensitive information to be disclosed, I must initial the line below for that information to be excluded and I understand I may be charged an additional fee to remove the sensitive information. _____

Initials, if applicable

Person/organization to receive the information for the purpose described above:

Name of Person/Organization	Complete Address/Phone

By signing this form, I acknowledge that I have read and agreed to the terms on *both* sides and/or pages of this form *Authorization for Three Rivers Hospital to Disclose Protected Health Information*

Signature (Patient or Person Authorized to give authorization)	**Date** (mm/dd/yyyy)
If signed by person other than patient, please print your name, provide reason, relationship & description of authority	

I understand that:

- Once my protected health information has been disclosed, the law does not always require the receiver of my information to be kept confidential.
- This authorization is voluntary and that I may refuse to sign this authorization.
- My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.
- By signing this authorization I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in affect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.
- I have the right to revoke this authorization by submitting a request in writing to:

  Three Rivers Hospital
  HIPAA Privacy Officer
  PO Box 577
  Brewster, WA 98812
- I have a right to inspect or to receive a copy of my protected health information.
- I have a right to receive a copy of this signed form.

For Office Use Only:

Information Requested	Dates
All Records	
Discharge Summary	
Radiology Report	
Radiology Image	
EKG Report	
Operative Report	
Progress Notes	
Consultation	
Laboratory Report	
Billing	
Pathology Report	
Other:	
Date Sent:	Sent By:

Release of Information INSTRUCTIONS

Complete this form and return it to Three Rivers Hospital one of the following ways:

Fax	**US Postal Mail**	**Present the form in person**
(509) 645-3311	Three Rivers Hospital Attn: Health Information Management Office PO Box 577 Brewster, WA 98812	Three Rivers Hospital Health Information Management Office 507 Hospital Way Brewster, WA 98812 *Monday through Friday, 9:00 AM to 4:00 PM*

To be valid, the authorization request must:

- ✓ Be in writing, dated and signed.
- ✓ Specify the information to be disclosed.
- ✓ Specify the entity or location to disclose the information
- ✓ Specify the person or persons to receive the information
- ✓ Specify the reason for requesting the information.

Three Rivers Hospital will make every effort to process your request in a timely manner. Our general guidelines for releasing information are:

Emergency care	*Immediate*
Other health care facilities requesting information for **continuation of care**	*Within 24 hours*
All other requests	*Within 10 business days*

Release of Information Fees will be charged for all requests that are not sent to other health care facilities for the purpose of continuation of care. Fees will be collected prior to the release of the medical records. The following fee schedule follows guidelines established by WAC 246-08-400. Fees are as follows:

Processing	$23.00
Copying	
Page 1 – 30	$ 1.04 per page
Additional pages	$ .78 per page
Radiology image disk	$10.00 per disk

Medical records will be sent via First Class US Mail. If you would like your records sent in quicker manner, shipping fees will be applied according to the carrier costs. Three Rivers Hospital makes every effort to protect our patients protected health information. We do not advise that records be faxed. However, if requested, we will fax records to a confirmed fax number with the requestor's express permission.

If you have any questions regarding the release of your protected health information, call Three Rivers Hospital, Health Information Management at (509) 645-3395. Office hours are Monday through Friday, 9:00 AM to 4:00 PM