Patient	Patient's Name:	Address:
	Date of Birth:	(City, State, Zip):
	Other Names Used:	Phone Number:
Authorization	**INFORMATION TO BE RELEASED FROM:**	**INFORMATION TO BE RELEASED TO:**
	Samaritan: □ Hospital **OR** □ Clinic **OR** □ Parkview Pediatrics	□ Patient (same as above)
	Name:	Name:
	Organization:	Address:
	Address:	(City, State, Zip)
	(City, State, Zip)	Phone:
	Phone:	Fax:
	Facility Fax:	(Facility only. We do not fax directly to a patient's personal fax number.)
	Delivery Options: □ Mail □Fax □ Release to MyChart (if available) □ Electronic (Please contact (509) 765-5606 ext 1160)	

Information

Purpose of Disclosure: □ Continuation of Care □ Personal □ Transfer of Care □ Insurance □ Legal □ Other: _____

Notice: I understand that there may be charges associated with my request for records. Such charges shall not exceed the amounts allowable under RCW 70.02.080.

Release the Following Records:

□ Abstract/Summary □ From: _____ To: _____
(includes history and physical, progress notes, consultations & test results)

□ Imaging Reports (X-ray, MRI, etc.) □ Image cd □ From: _____ To: _____

□ Billing and Payment Records □ From: _____ To: _____

□ Other Records: _____ □ From: _____ To: _____

Restrictions

Sensitive Information: I understand that all health care information in my records, including testing and diagnosis for HIV, sexually transmitted diseases, psychiatric disorders/mental health, drug and/or alcohol use will be released unless initialed below.

Do **NOT** send records regarding (check & initial all that apply):

□ HIV/AIDS _____ □ STDs _____ □ Psychiatric disorders/mental health _____ □ Drug/Alcohol abuse ____

Revocation: I understand that I have the right to revoke this authorization at any time except to the extent that Samaritan Healthcare has taken action in reliance on the authorization. To revoke this authorization, I must submit a written revocation to: Privacy Officer at Samaritan Healthcare, 801 E Wheeler RD, Moses Lake, WA 98837

Expiration: This Authorization ends (Please check ONE of the following options) : □ in 90 days from the date signed □ one year from date signed □ other: _____ (No longer than one year from date signed)

Disclosure: I understand that Samaritan Healthcare may not condition the Patient's healthcare on this authorization unless (1) the purpose of Samaritan Healthcare's evaluation and treatment is to obtain and disclosure information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research. I understand that information disclosed by Samaritan Healthcare pursuant to this authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations.

Signatures

Patient or legally authorized individual signature Date Relationship to patient
(parent, legal guardian, personal representative)

Minor Signature Date **GUARDIANSHIP PAPERS OR POWER OF ATTORNEY PAPERS ARE REQUIRED**
(signature of minor is also required if minor is age 13-17*)

*RCW 9.02.100 (1), State v. Koome, 84 Wn.2d 901, RCW 70.24.110, RCW 70.96A.095, RCW 71.34.500 & RCW 71.34.530

SAMARITAN HEALTHCARE

FORM: 005221
REVISED: MAY 2016

*Copy of ID required for verifying signature.
Label:

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION