Columbia County HEALTH SYSTEM
1012 South Third Street, Dayton, WA 99328-1696
(509) 382-2531

Dayton General Hospital	Columbia Family Clinic	Waitsburg Clinic	Booker Rest Home
Fax # (509) 382-3205	Fax # (509) 382-2748	Fax # (509) 337-6011	Fax # (509) 382-3217

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name:_____ MR#_____
Address:_____ Telephone #:_____
Previous Name(s):_____ Birth Date:_____
Date Requested By: _____ Upcoming Appointment_____ Yes _____ No

I Hereby Authorize:

_____
(Individual/Agency)
_____
(Address)
_____
(City, State, Zip Code)

To Provide Medical Information to:

_____
(Individual/Facility)
_____
(Address)
_____
(City, State, Zip Code)

Date(s) of treatment:_____

Data requested:

_____ Physician notes
___ ___ ___ Lab/Pathology Reports
___ ___ ___ X-Rays
_ __ Reports
_____ Films
_____ Operative Reports
_____ History and Physical
_____ EKG
___ ___ All health care records
_____ Other:_____

For the purpose of: _____
Permission to fax and/or send electronically _____ YES _____ NO

To be valid, this authorization must be dated within 90 days of the request for information. I may revoke this authorization in writing at any time, provided that the information has not yet been released. To view the process for revoking this authorization, please read the Privacy Notice to our patients. I understand that once Dayton General Hospital discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under Privacy laws. I understand I do not have to sign this authorization in order to receive health care benefits.

_____ _____
Patient Signature Date/Time Parent, Legal Guardian or Authorized Representative* Date/Time
{* Please provide documents to prove authority to sign on behalf of patient}

_____Witnessed by

By **checking** and **signing** below, I specifically authorize the release of the following confidential information:
_____ HIV test and test results and related information
_____ Sexually transmitted diseases
_____ Drug/alcohol diagnosis, treatment or referral information
_____ Psychiatric disorders/mental health

_____ _____
Patient Signature Date/Time Parent, Guardian or Authorized Representative* Date/Time
{* Please provide documents to prove authority to sign on behalf of patient}

_____Witnessed by