Columbia County HEALTH SYSTEM

1012 S 3rd Street, Dayton, WA 99328

Dayton General Hospital	Columbia Family Clinic	Waitsburg Clinic	College Place Clinic	Rivers Walk Assisted Living Facility
Fax: (509) 382-3205	Fax: (509) 382-2748	Fax: (509) 337-6011	Fax: (509) 593-4342	Fax: (509) 593-4911

AUTHORIZATION FOR THE 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)

Permission to fax and/or send electronically ☐ No ☐ Yes - Email and/or Fax#: _____

Dates of Treatment: _____

Data Requested:

- ☐ Physician Notes
- ☐ History & Physical
- ☐ Reports
- ☐ Other: _____
- ☐ Operative Reports
- ☐ X-Rays
- ☐ All Health Care Records
- ☐ Lab/Pathology Report
- ☐ EKG
- ☐ Films

For the purpose of: _____

To be valid, this authorization must be dated within 90 days of the request for information. This authorization may be revoked in writing at any time, provided that the information has not been released. To view the process for revoking this authorization please read the Privacy Notice to our patients. Once Columbia County Health System 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. The patient understands that they 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 documentation to prove authority to sign on behalf of the patient

_____
Witnessed by

By checking and signing below, I specifically authorize the release of the following confidential information.

- ☐ HIV test, Test Results, and Related Information
- ☐ Sexually Transmitted Diseases
- ☐ Drug/Alcohol Diagnosis, Treatment or Referral Information
- ☐ Psychiatric Disorders/Mental Health

_____ _____
Patient Signature Date/Time

_____
Parent/Legal Guardian or Authorized Representative* Date/Time
Please provide documentation to prove authority to sign on behalf of the patient

Witnessed by: _____