Columbia Basin Health Association
1515 E Columbia St, Othello, WA 99344
Phone: 509-488-5256
Fax: 509-331-1601 or 509-488-9939
medicalrecords@cbha.org

MR# _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
NOTE: NOT FOR SUBSTANCE USE DISORDER RECORDS

PATIENT'S NAME:_____ D.O.B.:_____

PREVIOUS NAME:_____ TELEPHONE:_____

FROM: **I hereby authorize for records maintained at:**	TO: **Release a copy of my health record on my behalf to:**
Name	Name
Address	Address
Phone/Fax	Phone/Fax

Records to be released: (initial below) **Dates to be released:** _____

_____ Medical Records _____ Pharmacy Records _____ Dental Records _____Eye Care Records _____ Billing Records
_____ Well Child Exam/Sports Physical _____ Hospital Records _____ Labs _____ EKG _____ X-Ray

Other: _____

Reason for Release: _____

Expiration Date (or event) _____
If you do not indicate a date or event, this authorization will expire 90 days from the date of signature.

REQUIRED Attestation Regarding Reproductive Health Records: (Initial the following)

_____ With my initials here and by signing below I attest that, if the records requested include reproductive health information, it will not be used for the purposes prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) and that the purpose of this health information is not to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes. I understand that if I knowingly lie or falsely represent the reason for the release, I may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6.

OPTIONAL Special Consents: *(Records pertaining to these conditions below may not be released without patient's initials.)*

My **initials** below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:
_____ Reproductive Health (minors – any age) **_____ Mental Health/Psychiatric (minors - 13 and older)**
_____ Sexually Transmitted Diseases (minors - 14 and older) **_____ HIV/AIDS**

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization.

By signing below, I hereby release Columbia Basin Health Association and its staff from all legal responsibility that may arise from the actions hereby authorized. I understand that once CBHA discloses this information per these instructions, the information may be subject to re-disclosure and may no longer be protected by HIPAA regulations.

PATIENT'S SIGNATURE:_____DATE:_____

Representative/Parent/Legal Guardian:_____ DATE:_____
(Circle One)

CBHA Use Only:
Request Completed by:_____**/date:**_____ Mailed / Faxed / Hand carried:_____ / date:_____

❑ No Payment required ❑ $5/CD # of pages:_____ (x 0.25 - 1st 100 pg/0.10 add'l pgs) = _____ + Postage:_____ = _____Total

Payment/receipt received by: _____/date: _____ Payment: _____Cash Check CC