Trios Health

Authorization to Disclose Health Information - *Please complete both pages.*

I. I authorize disclosure of the following information (check appropriate boxes below):

✓	Record Type	Dates	
		From	To
	Information about my last hospitalization		
	Emergency Room Record		
	History and Physical Report		
	Consultation Report		
	Operative Report		
	Lab Results (Specify)		
	X-Ray Reports (Specify)		
	Discharge Summary		
	Information related to (specify)		
	Entire record		

II. I would like the following information excluded in the materials disclosed (check applicable boxes below:

___Alcohol/Drug abuse.
___Mental health
___Sexually transmitted disease
___HIV/AIDS

If any of these boxes is unchecked, the following notification applies: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

III. I would like the information described above prepared using the following process:

_____ Photocopy ____Electronic File

IV. I would like the information described above delivered using the following process:

___Mailed ___Sent via secure e-mail

___Picked up by the following individual: _____

V. I understand that:

A. Authorizing a disclosure of health information is voluntary. Trios Health will not condition treatment on my providing this authorization.
B. I have the right to revoke this authorization at any time by providing written notice to the Medical Record/Health Information Management Department.
C. If I revoke this authorization, the revocation will not apply to information that has already been disclosed in reliance on this authorization.
D. Once information is disclosed, it may be subject to re-disclosure by the recipient and may not be protected by federal and state privacy laws.

Patient's Name_____

Patient's Birthdate:_____

Phone Number:_____

VI. This authorization will expire on (insert date) _____. If not specified, this authorization will expire 90 days from when it was signed.

VII. I would like the information above disclosed from and to the individuals or organizations below:

✓	FROM	✓	TO
☐ ☐	Trios Health 900 South Auburn Street Kennewick, WA 99336 Trios Medical Group	☐	Name of person or organization_____ Street Address_____ City, State, Zip_____ FAX _____ Phone _____ E-mail address_____
☐	Name of person or organization_____ Street Address_____ City, State, Zip_____ FAX _____ Phone _____ E-mail address_____	☐ ☐	Trios Health 900 South Auburn Street Kennewick, WA 99336 Trios Medical Group

Purpose of Requested Disclosure:

☐ Continuity of Care
☐ Insurance
☐ Attorney
☐ Personal Records
☐ Other : _____

CHARGES MAY BE APPLIED FOR RECORDS REQUESTS

_____ _____ _____

Signature of Patient or Legal Representative | Relationship to Patient | Date

FOR OFFICE USE ONLY

Patient ID ☐ Driver's License #_____ ☐ Other: _____ ID of Person Picking Up Information: ☐ Driver's License #_____ ☐ Other: _____ ID Verified by:_____	Account #:_____ MRN:_____ Date of Release:_____
PLEASE PROVIDE A COPY TO THE PATIENT. ONE COPY SHOULD BE SENT WITH INFORMATION BEING DISCLOSED.	