CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Patient Authorization to disclose, release, or obtain protected health information

Patient Information:

Name:	Birthdate:	Phone:	
Street Address:	City:	State:	Zip:
Email Address:	Former name(s)/Alias:		

Purpose of Request (check one):

	Provider		Attorney		Insurance		Personal		PFMLA		Other(specify):

Recipient of Records (Provider, attorney, insurance, self):

Name/Facility:	Phone:	Fax:	
Street Address:	City:	State:	Zip:

Records to be disclosed: Date range _____to_____ OR Most recent 2 years (default if no dates listed)

Check all that apply: (Below are the more frequently requested documents. This does not constitute your entire medical record, which you have the right to request)

	Radiology Reports (Xray, CT, MRI, US)		Diagnostic Images (prepped by Radiology dept)
	EKG		Emergency room records
	Lab Reports		Discharge Summary
	Pathology Reports		History and Physical
	Clinic/ Physician Notes		Operations and Procedures
	Physical Therapy notes		Medication List
	Immunization (shot) Record		Billing Records
	Behavioral/ Mental Health treatment		Substance or drug abuse records
	HIV/AIDS testing and results		Alcohol abuse records
	Other (Specify):		

Format for Records:

	Paper		Fax		Email (Provide):

By Signing this page, I acknowledge that I have read and agree to the terms on both sides of this form.

Signature (Patient or Person Authorized to give Authorization)	Date	Time:
Printed name, and Relationship if different than the patient.		

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Minors: A minor patient's signature is required in order to release the following information:

- Birth control and pregnancy related care – Any age. *RCW 9.02.100. See State v. Koome, 84 Wn.2d 901 (1975)*
- Sexually transmitted diseases including HIV and AIDS – beginning at age 14. *RCW 70.24.110.*
- Outpatient behavioral health services including; Alcohol and/or drug abuse and mental health conditions – beginning at age 13. *RCW 71.34.530.*

Patient Rights: I understand I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment, or enrollment).

I understand I have the following rights to:

- Inspect or receive a copy of my protected health information
- Receive a copy of this signed form
- Refuse to sign this form for authorization to disclose or release my protected health information
- Use email to request and receive my medical records via email, and I assume the risk of this unprotected format for delivery

Revocation and Re-disclosure: I understand that I may revoke this authorization at any time by notifying the Cascade Medical Records department in writing. Cancellation will not apply to information/records already issued in response to this authorization. Cascade Medical is not responsible for any unauthorized re-disclosure of my healthcare information by others, including the person or facility receiving the records requested in this authorization.

Expiration: This authorization will expire one year from the date signed unless I cancel before that time.

Request for copies of medical records are subject to reproduction fees, in accordance with federal/state law.

This authorization form can be sent back to us by postal mail, email, or fax.

Cascade Medical
817 Commercial st
Leavenworth, WA 98826
Medrec@cascademedical.org
Phone: 509-548-5815
Fax: 509-548-2524

For CM Staff use only

Date Completed: _____ Initials: _____
Date Released: _____ Initials: _____
ID Check: _____