Ritzville Medical Clinic
903 S Adams – Ritzville, WA 99169
Phone: (509) 659-1200 Fax: (509) 659-0632

Date of Request_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name_____ Date of Birth:_____

Address:_____

Phone Number:_____

☐ **I authorize Ritzville Medical Clinic to release information to:**

_____
Name/ Facility or Provider

_____ _____ _____
Address City, State, Zip Code (Area Code) Phone Number

☐ **I authorize the following to release information to Ritzville Medical Clinic:**

_____
Name/ Facility or Provider

_____ _____ _____
Address City, State, Zip Code (Area Code) Phone Number

I. MY AUTHORIZATION **You may use or disclose the following health care information (check all that apply:)**

☐Health care information for the following time period ☐ 1 yr ☐ 2 yr ☐ 5 yr
☐ All health care information in my medical record.
☐ Healthcare information in my medical record relating to the following treatment or condition:_____
☐ Health care information in my medical record for the date(s):_____
☐ Other (e.g. x-ray, labs, bills), specific_____

You may use or disclose the following health care information regarding testing, diagnosis, and treatment for: (check and initial all that you wish to be disclosed)

☐ HIV / AIDS _____ ☐ Sexually Transmitted Diseases_____ ☐ Psychiatric disorders_____ ☐ Drug/Alcohol use_____

Reason(s) for this authorization: (check all that apply)

☐ At my request.
☐ Other:_____

This authorization ends: (check one)

☐ In 90 days from the date signed.
☐ On (date):_____

II. MY RIGHTS

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study; or
- To receive health care when the purpose to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by East Adams Rural Hospital based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization is to: Fill out a revocation form, available from East Adams Rural Hospital, or to write a letter to East Adams Rural Hospital. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or Legal Representative Signature_____ Date:_____

Relationship to Patient:_____

Witness Signature_____ Date:_____