Medical Records Release Form

Tri-Cities Community Health • Attn: Health Records
800 West Court Street, Pasco, WA 99301 • Phone: 509.547.2204 • Fax: 509.545.3960

Authorization for TCCH to Exchange Protected Health Information (*Required)

*Patient Name: _____ *Date of Birth: _____

Previous Name: _____ *Daytime Phone: _____

Address: _____

I, the client named above, hereby authorize Tri-Cities Community Health (TCCH) to exchange the health information designated below with the person or organization named below.

I authorize TCCH to: ☐ Release To ☐Obtain From via *(choose one)* ☐Email ☐Fax ☐Mail

Name: _____ Email: _____

Address: _____ Fax: _____

City: _____ Phone: _____

Types of Information to Release:

☐Billing Records ☐Imaging/Diagnostic Reports ☐Medication List

☐Chart Notes ☐Immunizations ☐OB Records

☐Dental: ☐Records ☐X-rays ☐Lab and Pathology Reports ☐Other _____

☐All health care information (excluding sensitive information listed see below) for the last 2 years, unless specified.

☐Specified Duration: _____

I understand that my protected health information may contain information regarding diagnosis/treatment related to psychiatric, psychological or mental conditions, drug and or alcohol use or abuse, sexually transmitted infections (STI), acquired immune deficiency syndrome (AIDS), and or HIV status and genetic testing.

I consent for the following information to be disclosed: (mark any/all that apply):

☐Drug and/or alcohol use ☐Psychiatric disorder/mental health

☐ HIV (AIDS virus) ☐Sexually transmitted infections

*Reason for Authorization: ☐At the request of the individual; ☐Other _____

*Expiration date: ____/____/____ OR ☐Event (one time release): _____

If date is not specified, this request will expire in 90 days from the date of signature.

If the release is for the patient's **EMPLOYER** or **FINANCIAL INSTITUTION** for reasons other than payment, this authorization will remain valid for only 90 days. Patient may revoke this authorization at any time prior to expiration by notifying TCCH in writing except (i) to the extent that action has been taken in reliance on this authorization, or (ii) if the purpose of the disclosure of substance use disorder (SUD) information is for payment, treatment or health care operations.

The information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by federal law. State and federal law specifically requires that any patient medical record and/or personal health care information containing drug and alcohol diagnosis and treatment, mental health and sexually transmitted infections, including HIV/AIDS are privileged and confidential and may only be disclosed by express authorization, except as required by law. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug abuse Patient Records, 42 CFR Part 2 and Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in such applicable laws.

I understand that I may refuse to sign this authorization. TCCH may not condition treatment, payment, enrollment or eligibility on the authorization of this release.

Electronic Signatures. This Medical Records Release form (Agreement) is, and related documents entered into in connection with this Agreement are, deemed signed when a party's signature is delivered electronically. The signor is executing this Agreement electronically and intends to be bound by the Agreement and agrees that the electronic signature shall be deemed original signatures having the same legal effect as original signatures to the fullest extent permitted by applicable law, including the Federal Electronic Signatures in Global and National Commerce Act, and any similar state law based on the Uniform Electronic Transactions Act, and the parties hereby waive any objection to the contrary. The signor acknowledges that this term is hereby incorporated into the Agreement.

_____ _____ _____

*Signature/Legally Responsible Party Relationship to Patient *Date

A minor's signature alone is sufficient to release health care information related to (1) sexually transmitted diseases, including HIV/AIDS (age 14+), (2) alcohol and/or drug abuse (age 13+), (3) mental health information (age 13+), (4) birth control services, (5) abortion services, and (6) prenatal care services. Authorization for disclosure of sexually transmitted disease, mental health or SUD information of individuals aged 13 or older must be signed by the client.

_____ _____

Signature of Minor Patient Date