Willapa Harbor Hospital

PO Box 438, South Bend, WA 98586
Phone: 360-875-5526 Fax: 875-0592

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I request and authorize Willapa Harbor Hospital to release medical records for:

_____

Patient *Date of Birth* *Medical Record #*

To the following:

Name: _____

Address: _____

For the purpose of:
[ ] Continuity of care.
[ ] Other: _____

This request and authorization applies to:
[ ] All healthcare information
[ ] Specific healthcare information as indicated: _____

By INITIALING, I specifically authorize the release of the following confidential information:
_____ HIV test, test results and related information including high-risk behavior documentation.
_____ Drug/Alcohol diagnosis, treatment, or referral information.
_____ Mental Health treatment information.
_____ Other (specify): _____

This authorization is valid for 90 days from the date of signature unless cancelled by written notice by the patient/legal guardian.

_____ _____

Signature of patient or legal guardian *Relationship to patient*

_____ _____

Witness *Date*

OFFICE USE ONLY

HAS THE HEALTHCARE INFORMATION BEEN RELEASED? _____NO _____YES

SIGNATURE OF STAFF RELEASING INFORMATION: _____