



Columbia
County
HEALTH SYSTEM

1012 South Third Street, Dayton, WA 99328-1696
(509) 382-2531

Dayton General Hospital
Fax # (509) 382-3205

Columbia Family Clinic
Fax # (509) 382-2748

Waitsburg Clinic
Fax # (509) 337-6011

Booker Rest Home
Fax # (509) 382-3217

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ MR# _____

Address: _____ Telephone #: _____

Previous Name(s): _____ Birth Date: _____

Date Requested By: _____ Upcoming Appointment _____ Yes _____ No

I Hereby Authorize:

(Individual/Agency)

(Address)

(City, State, Zip Code)

To Provide Medical Information to:

(Individual/Facility)

(Address)

(City, State, Zip Code)

Date(s) of treatment: _____

Data requested:

- | | |
|-----------------------------|-------------------------------|
| _____ Physician notes | _____ Operative Reports |
| _____ Lab/Pathology Reports | _____ History and Physical |
| _____ X-Rays | _____ EKG |
| _____ Reports | _____ All health care records |
| _____ Films | _____ Other: _____ |

For the purpose of: _____

Permission to fax and/or send electronically _____ YES _____ NO

To be valid, this authorization must be dated within 90 days of the request for information. I may revoke this authorization in writing at any time, provided that the information has not yet been released. To view the process for revoking this authorization, please read the Privacy Notice to our patients. I understand that once Dayton General Hospital discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under Privacy laws. I understand I do not have to sign this authorization in order to receive health care benefits.

Patient Signature Date/Time Parent, Legal Guardian or Authorized Representative* Date/Time

{ * Please provide documents to prove authority to sign on behalf of patient }

Witnessed by

By checking and signing below, I specifically authorize the release of the following confidential information:			
_____	HIV test and test results and related information		
_____	Sexually transmitted diseases		
_____	Drug/alcohol diagnosis, treatment or referral information		
_____	Psychiatric disorders/mental health		
_____	Date/Time	Parent, Guardian or Authorized Representative*	Date/Time
{ * Please provide documents to prove authority to sign on behalf of patient }			
_____	Witnessed by		