



AUTHORIZATION FOR LAKE CHELAN HEALTH TO USE OR DISCLOSE MY HEALTH CARE INFORMATION.

Lake Chelan Health P.O. Box 908 Chelan, WA 98816-0908	Phone: (509) 682-3300 Fax: (509) 682-1124	Health Information Management E-Mail: medrec@lch.net	Method to be sent: <input type="checkbox"/> MAIL <input type="checkbox"/> PICK UP <input type="checkbox"/> FLASHDRIVE <input type="checkbox"/> FAX <input type="checkbox"/> E-MAIL
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Patient Name: _____ Date of Birth: _____
 Previous Name: _____

Authorization is hereby granted for release of information

RELEASE FROM:	RELEASE TO:
Name: _____	Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____
E-Mail: _____	E-Mail: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment/condition: _____
- Health care information in my medical record for the date(s): _____
- Other (e.g., X-Rays, Bills), specify date(s): _____

Exclude the following information:

<input type="checkbox"/> HIV (AIDS virus)	<input type="checkbox"/> Sexually transmitted diseases
<input type="checkbox"/> Psychiatric disorders/mental health	<input type="checkbox"/> Drug and/or alcohol use

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

- At my request
- Check only if LCCH requests the authorization for marketing purposes
- Other (specify) _____
- Check only if LCCH will be paid or get something of value for providing health information for marketing purposes

This authorization ends:

- In 90 days from the date signed
- On (date) _____ (no longer than 90 days from date signed)
- When the following event occurs _____

II. My Rights

I understand that 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 is to create health care information for a third party.

I understand that my **alcohol and/or drug treatment records** are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 C.F.R Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Lake Chelan Health 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 are:

- Fill out a revocation form. A form is available from Health Information Management at Lake Chelan Health. **OR**
- Write a letter to the Privacy Officer, Lake Chelan Health (at address above).

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 legally authorized INDIVIDUAL SIGNATURE	_____ Date	_____ Time
_____ WITNESS and/or PERSON SIGNING ON BEHALF OF PATIENT	_____ WITNESS NAME and/or RELATIONSHIP TO PATIENT	