LAKE CHELAN HEALTH

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

Lake Chelan Health		**Health Information Management**		**Method to be sent:**			
P.O. Box 908	**Phone:**	**(509) 682-3300**	**E-Mail:**	☐ **MAIL**	☐ **PICK UP**	☐ **FLASHDRIVE**	
Chelan, WA 98816-0908	**Fax:**	**(509) 682-1124**	**medrec@lcch.net**	☐ **FAX**	☐ **E-MAIL**		

Patient Name: _____ **Date of Birth:** _____

Previous Name: _____

Authorization is hereby granted for release of information

RELEASE FROM:				**RELEASE TO:**			
Name	Lake Chelan Health			**Name:**			
Address:	PO Box 908			**Address:**			
City	Chelan	**State:** WA	**Zip:** 98816	**City**		**State:**	**Zip:**
Phone	509-682-3300			**Phone**			
Fax	509-682-1124			**Fax**			
E-Mail	medrec@lcch.net			**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:

- ☐ **HIV (AIDS virus)**
- ☐ **Psychiatric disorders/mental health**
- ☐ **Sexually transmitted diseases**
- ☐ **Drug and/or alcohol use**

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

- ☐ **At my request**
- ☐ **Other (specify)** _____
- ☐ **Check only if LCCH requests the authorization for marketing purposes**
- ☐ **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**
- ☐ **When the following event occurs** _____
- ☐ **On (date)** _____ **(no longer than 90 days from date signed)**

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**