



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION				
Patient Name: _____		Date of Birth: ____ / ____ / ____		
Last	First	M.I.		
Address: _____		Phone: (____) _____		
City	State	Zip Code		
Records to be released from:				
☐ Lake Chelan Health PO Box 908, Chelan, WA 98816 Phone: (509)682-3300 Fax: (509)682-1124 Email: medrec@lcch.net				
☐ Other _____				
Records to be released to: (eg. Insurance Company, Attorney, Physician, Patient)				
Name of Person/Entity (Who may have the information?):		Phone: _____		
		Fax: _____		
Address of Person/Entity (Where do you want the information sent?):		Email: _____		
Street	City	State	Zip Code	
PURPOSE OF RELEASE				
☐ Continuing/Transferring Care	☐ Attorney/Legal	☐ Insurance Company	☐ Other	
☐ Personal Use	☐ Billing/Claims	☐ School/Employment		
DELIVERY METHOD				
I authorize my records to be delivered in the following method:			Imaging is available on CD or QR code from the Radiology Department only.	
☐ US Mail-Paper Only ☐ Fax ☐ Flash Drive				
☐ Secure/encrypted Email				
INFORMATION TO BE DISCLOSED				
☐ Office Visit	☐ Immunizations	☐ Discharge Summary	☐ X-Ray Imaging	Specific Dates/Years:
☐ Labs	☐ Procedure Report	☐ History & Physical Report	☐ X-Ray Report	
☐ Medications	☐ ER Reports	☐ Billing Records	☐ Other: _____	
SENSITIVE HEALTH INFORMATION				
If your health information contains any of the following, please check all that apply to exclude.				
By checking a box, you are excluding the release of sensitive information:				
☐ Alcohol/Drug or Substance Abuse	☐ Behavioral Health/ Psychotherapy Records	☐ Sexually Transmitted Infections	☐ HIV/AIDS Testing/ Results	
AUTHORIZATION				
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 HIPAA of 1996, 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Once health information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. - Requests for copies of medical records subject to reproduction fees in accordance with federal/state regulations. - I have the right to revoke this authorization at any time. Revocation must be made in writing and mailed to the Health Information Management Department at Lake Chelan Health PO Box 908, Chelan, WA 98816 or by email at medrec@lcch.net . Revocation will not apply to information that has already been disclosed in response to this authorization. This authorization will expire in 90 days from the date signed unless otherwise specified: ☒ 1 year ☐ Other: _____				
Printed Name of Patient/Legal Representative: _____		Relationship to Patient: _____		
Signature of Patient/Legal Representative: _____		Date: _____	Time: _____	
Signature of Minor (Age 13-17) if Requesting Sensitive Information: _____				