GRAYS HARBOR COMMUNITY HOSPITAL

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

915 Anderson Drive · Aberdeen, WA 98520
Health Information Request Phone Line: 360-537-5196
Fax Line: 360-537-0588

Picture ID is required

Patient Name:_____ Previous Name:_____
(Please print legibly) (Please print legibly)

Date of Birth:_____ Phone:_____

I hereby request, authorize and direct Grays Harbor Community Hospital to release my protected health information as follows:

Date(s) of Service:_____ Release to: _____ (Name) _____ (Address) _____ (City, State, Zip) Purpose or need for the release: _____ _____ _____ Expiration Date (or event): _____	Information Requested: ☐ Inpatient ☐ Outpatient ☐ Last two years ☐ Other:_____ _____

_____
Signature of Patient (or representative) Date Relationship to Patient

DISCLOSURES REQUIRED SPECIAL AUTHORIZATION:

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for items checked:

☐ HIV / AIDS Virus ☐ Mental Health / Psychiatric Disorders
☐ Sexually Transmitted Diseases ☐ Drug, Alcohol, Abuse / Treatment

_____
Signature of Patient (or representative) Date Relationship to Patient

This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Joint Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per our instructions, the information is subject to re-disclosure and may no longer be protected by Federal Privacy rules.

For Facility Use
Chart #:_____ M#:_____ G#:_____
Date Received:_____ Date Information Released:_____
Person / Department Sending Records:_____