GRAYS HARBOR COMMUNITY HOSPITAL

GRAYS HARBOR COMMUNITY HOSPITAL
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

M#_____

G#_____

915 Anderson Drive Aberdeen, WA 98520
Health Information request line: Phone (360) 537-0585 FAX (360) 537-0588

Patient Name: _____ Previous Name _____
(Please Print) (Please Print)

Birth date: _____ PHONE _____

I hereby request, authorize and direct GRAYS HARBOR COMMUNITY HOSPITAL to release my protected health information as follows:

Dates of Service: _____

To: _____
(Name)

_____
(Address)

_____
(City, State, Zip)

Purpose or need for the release:

_____

_____

Expiration Date (or event) _____
No more that 90 days from signature

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 check:

- ❑ 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:
Date Received: _____ Date Information Released: _____ Chart # _____

Person/Department Sending Records: _____

*********PICTURE I.D. REQUIRED*********