Patient Authorization to Disclose Protected Health Information

Patient Name:_____ Date of birth: _____

I hereby authorize the following entities designated below (check all that apply):

☐ Grays Harbor Community Hospital
Fax: (360)537−0588

☐ Harbor Medical Group
Fax: (360)537−6198

☐ HarborCrest Behavioral Health
Fax: (360)537−6240

To exchange (disclose and receive) my health care information with the entities and/or individuals listed below:

Name: _____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

The entities and/or individuals designated above are authorized to disclose and receive the following (check one):

☐ All health care information in my medical record. (Last 2 years)

☐ Only the following health care information in my medical record (Check all that apply):

- ☐ Health care information in my medical record relating to the following treatment or condition:_____
  _____
- ☐ Health care information in my medical record for the date(s): _____
- ☐ Specific types of health care information 9e.g., x−rays, bills, inpatient evaluation):_____
  _____

I specifically authorize the disclosure of testing, diagnosis, and treatment information related to the categories below (check all that apply). If none of the below boxes are checked, no information related to categories below will be disclosed pursuant to this authorization. I understand that HarborCrest Behavioral Health will not disclose any of my health care information it maintains if the substance use disorders box is not checked.

☐ HIV/AIDS Information
☐ Sexually transmitted diseases
☐ Mental health
☐ Substance use disorders

I understand that my substance use disorder records may be protected under the federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless permitted by law.

The disclosure health care information is for the following purpose(s) (check all that apply):

☐ Treatment
☐ Payment
☐ Insurance
☐ Attorney
☐ At my request
☐ Other (specify) _____

This authorization will expire (check one):

- ☐ One year from the date signed
- ☐ On (date):
- ☐ When the following event occurs:

I understand that I have the right to revoke this authorization in writing submitted at any time to the Grays Harbor Community Hospital address above. I understand that my revocation is not effective to the extent that any person or entity has already acted in reliance on this authorization. I understand that I will not be denied treatment if I refuse to sign this authorization, unless research−related treatment is going to be provided, or if health care services will be provided solely for the purpose of providing health information to someone else and this authorization is necessary to make such disclosure. I also understand that I might be denied services at HarborCrest Behavioral Health if I refuse to authorize disclosure of my health care information for treatment, payment or health care operations. I understand that information disclosed pursuant to this authorization may be re−disclosed by the recipient and may no longer be protected by federal or state law. Upon request, I will be provided with a copy of this authorization.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship / Description of Authority

GRAYS HARBOR COMMUNITY HOSPITAL
Quality care close to home

M.ROIREQ

Release of Information Request

mr367_099 (rev 12/03/2018)

Internal Use Only:

Medical Record M#	
Visit G #	
ROI Request #	