AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Fees: A $25 Clerical Fee will be charged for patient's requesting personal records or third party (eg- insurance company, attorney); plus $1.20 per page for 1-30 pages; $.90 per page for 31 + pages. There is no fee for transfer of care record request.

INTERNAL USE ONLY

PATIENT NAME: _____
(First) (Middle) (Last)

Date of Birth:_____ **Phone Number**: _____

Any Previous &/or Other Name(s):_____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION

☐ TO ☐ FROM

Cascadia Women's Clinic, LLP
Suzanne Slayton-Milam, MD; Lisa Gibbons, DO; Mieke Lane, DO; Amanda Allen, MD; Jennifer Ivy, CNM; Lisa Amoruso, CNM

900 NE 139th St, Suite 206
Vancouver, WA 98685
Telephone: 360-433-0022 Fax: 360-433-6159

FORMAT OF RECORDS (select only one)
☐ EMAIL (Encrypted) ☐ Paper
☐ CD (Encrypted) ☐ Fax

PERSONAL USE (select only one)
☐ Pickup ☐ Mail ☐ EMAIL

☐ TO ☐ FROM _____

_____

PURPOSE OF RELEASE: (Please check):
☐ Changing Clinic ☐ Continuing Care ☐ Legal ☐ Insurance ☐ Personal Use ☐ Other_____
(Please Specify)

PERMISSON TO FAX INFORMATION Yes ☐ No ☐

I specifically consent to the faxing of my records. All faxed material will contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot always be guaranteed.

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

1) We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
2) You may inspect a copy of the protected health information to be used or disclosed;
3) You may refuse to sign this Authorization;
4) We must provide you with a copy of the signed Authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and with the exception that we have not already used and disclosed the information as instructed by this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire in 90 days from the date of signing or shall remain in effect for the period reasonably needed to complete request.

TYPE OF INFORMATION TO BE RELEASED

ALL ITEMS BELOW

☐ Medication Summary ☐ History & Physical ☐ Immunizations
☐ Lab/ Path Reports ☐ Clinic Notes ☐ **LAST TWO YEARS ONLY**
☐ Operative Reports/ Discharge ☐ Imaging ☐ **OTHER**

For the following dates of service From: _____ To: _____

INITIAL BELOW **For the Release of Protected or Sensitive Information**: I understand that certain information cannot be released without specific authorization as required by State/Federal Law(s). By initialing the categories below I authorize the release of the following protected or sensitive information:

___ Drug/ Alcohol Treatment ___STD ___Genetic Testing ___HIV/ AIDS ___Mental Health

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Minor Patient (age 13-17) _____ Date_____
Minors Signature required in addition if between the age of 13-17 years old (Washington State Law)

_____ _____ _____
Signature of Patient or Representative **Relation to Patient** **Date Signed**

Email form to: sbaker@cascadiawc.com or USP mail to clinic address above attention Sarah.