

## 1821 N. LeClerc Road #1 Cusick, WA 99119 509-447-7111

## Medical Records FAX 509-445-5020 CONSENT/ AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name:		D	OB:					
LAST	IRST	MI						
I hereby Consent and Authorize C	amas Center	Clinic To:						
Initial at least one								
Send a copy of my specific health inf								
Receive a copy of specific health information from person or organization named below								
Orally exchange specific health infor	mation with pers	on or organization named	below					
Agency Name:								
Address:		City:	State:					
Telephone:		_ Fax:						
CONSISTING OF (check all that applies  Last Year's Medical Record	s):							
Most Recent								
Other:	· as							
FOR THE PURPOSE OF: (describing th	e purpose of a	sclosure) $\square$ Continuing	Care; D Other:					
		<del></del>						
If the information to be disclosed contains	any of the types	of records or information	listed below, additional laws relating					
to the use and disclosure of the information								
federal regulations governing confidentiali								
otherwise provided for in this regulation. I	agree to the rel	ease of the information i	nitialed below.					
HIV/AIDS and STD information								
Mental health services/psychotherap								
Drug/alcohol treatment or rehabilitat	ion							
I understand that the information used or dis	closed pursuant t	o this authorization may be	subject to re-disclosure and no longer					
I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS								
information, mental health information, and o	drug/alcohol treati	ment or rehabilitation.						
You may revoke this authorization in writing	at any time. If you	ı revoke vour authorization	the information described above may					
You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when we have								
taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.								
To revoke this authorization, please send a			Center Clinic, 1821 N LeClerc RD # 1,					
Cusick, WA 99119 and state that you are rev	voking this author	ization.						
You do not need to sign this authorization. R	efusal to sign this	authorization will not adve	rsely affect you ability to receive health					
care or reimbursement for services. The only	circumstance when	nen refusal to sign means y	ou will not receive health care services					
is if the health care is solely for the purpose	of providing healt	n information to someone e	se and the authorization is necessary					
for you to make that disclosure.								
I have read this authorization and I understand it. Unless revoked, this authorization will expire in one year or specify								
Signature	Date		Phone Number					



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	LAST	FIRST	MI			
I hereby Co	onsent and Aut	horize <u>Camas Cen</u>	ter Clinic To:			
Initial at le						
Receive	a copy of specific	health information to phealth information from	n person or orga	nization named below		
Orally ex	cchange specific n	ealth information with p	person or organiz	ation named below		
<b>Agency Nam</b>	ie:					
Address:				City:	State:	
relepnone: _			Fax:			
Last Yea Most Re		at applies): rd				
FOR THE PU	RPOSE OF: (des	cribing the purpose o	of disclosure) 🗆	Continuing Care;	□ Other:	
to the use and federal regula otherwise pro	d disclosure of the tions governing co vided for in this re	information may apply infidentiality, 42 CFR, I gulation. I agree to the	. I understand th Part 2, and cann	at the records produce ot be disclosed withou	low, additional laws relating ed may be protected under t my written consent unless below.	
Mental h	and STD informa ealth services/psy ohol treatment or	chotherapy				
I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, and drug/alcohol treatment or rehabilitation.						
no longer be u taken action in To revoke this	sed or disclosed for reliance on the aut authorization, pleas	the purposes described horization or the authori	d in this written au zation was obtair nent to: Privacy O	ithorization. The only ex ned as a condition of ob	mation described above may xception is when we have taining insurance coverage. linic, 1821 N LeClerc RD # 1,	
care or reimbu is if the health	rsement for service	s. The only circumstand	e when refusal to	sign means you will no	ct you ability to receive health of receive health care services ne authorization is necessary	
I have read this	s authorization and	I understand it. Unless	revoked, this auth	orization will expire in o	one year or specify	
Signature <u> </u>		D	ate	Phone	e Number	