MOSES LAKE
COMMUNITY HEALTH CENTER
605 S Coolidge Street ■ Moses Lake, WA 98837
1450 1st Avenue SW ■ Quincy, WA 98848
Phone: 509-764-6111 ■ Fax: 509-764-0193

Internal Use Only:
Form Received by: _____
Chart #: _____ PCP: _____
Records Released: ❑ Yes ❑ No
Released by: _____ Date: _____

❑ Medical ❑ Dental ❑ Both

RELEASE OF INFORMATION

There may be a charge for copies of your medical record unless your copies are being sent to another physician or healthcare facility.

Patient's Name: _____ Birth Date: _____
(Please Print) LAST FIRST MI

Other name your record might be listed under: _____ Phone #: _____

Information to be Released ***From***:	Information to be Released ***To*:**
_____ Organization/Person Name	_____ Organization/Person Name
_____ Street Address City, State, Zip	_____ Street Address City, State, Zip
_____ Phone Fax	_____ Phone Fax

Type of Medical Records Requested:

❑ Complete medical record abstract (includes 1 year of chart notes, most recent labs/pathology, and diagnostic imaging reports)

❑ My health information relating only to the following treatment or condition: _____

❑ My health information only for the following date(s): _____

❑ Other: _____

Sensitive Information: This authorization includes the release of the following sensitive information unless specifically excluded. Please check if you **DO NOT** want this released: ❑ Mental Health ❑ HIV/AIDS ❑ Sexually transmitted diseases ❑ Drug and alcohol treatment ❑ Reproductive care (minors only) ❑ Other:
_____

Reason for Request: ❑ Personal ❑ Transfer of Care ❑ Disability ❑ Insurance ❑ Legal Review ❑ Other: _____

Minors Age 13-17: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive health such as: contraception, pregnancy, pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

This authorization will expire 90 days from the date signed unless otherwise stated: _____

Patient signature: _____ Date: _____

Or parent/legal guardian: _____ Date: _____

Relationship to patient, if other than patient: _____
(You may be required to provide legal documentation as proof for power of attorney or guardianship)

As a courtesy, Moses Lake/Quincy Health Center is able to provide translation of this document in Spanish or Russian. We require your signature on the English version of this document to place and maintain in your permanent medical/dental record.
Patient received translation of this form in ❑ Spanish ❑ Russian by: _____

Federal laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.