Mid-Valley Hospital
PO Box 793 - Omak, WA. 98841 www.mvhealth.org
Mid-Valley Hospital
Mid-Valley Clinic
509.826.1760

Patient Authorization to Disclose, Release, and/or Obtain Protected Health Information

Copy of PHOTO ID Required

1. Patient Information

Patient Name (Last, First MI): _____ Date of Birth: _____

Former Name(s)/Alias: _____ Phone Number: _____

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

2. Records to be Released From:

Mid Valley Hospital and Clinic 810 Jasmine Street Omak, WA 98841

3. Records to be Disclosed to: (*e.g. Insurance Company, Attorney, Provider, Patient)*

☐ Attorney ☐ Insurance ☐ Provider ☐ Personal ☐ Other (specify): _____

Name (**WHO** may have information): _____

Phone Number: _____ FAX Number: _____ Email: _____

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

4. Purpose of Release

☐ Attorney ☐ Insurance ☐ Provider ☐ Personal ☐ Other (specify): _____

5. Delivery Method *(I authorize my records to be delivered in the following method)*

☐ US Mail ☐ Email ☐ Patient Portal ☐ Fax ☐ Pick up at Mid Valley Hospital

6. Information to be Disclosed: **SPECIFIC DATES/YEARS:**_____

☐ Office Visit ☐ Immunizations ☐ Discharge Summary ☐ Billing Records ☐ History & Physical

☐ Labs ☐ Radiology/Xrays ☐ Emergency Report ☐ Surgery Report ☐ Other (specify): _____

7. Sensitive Health Information *(By checking a box below, you authorize the release of sensitive information)*

☐ Attorney ☐ Insurance ☐ Provider ☐ Personal ☐ Other (specify): _____

8. Authorization

I understand that: 1) Requests for copies of medical records subject to reproduction fees in accordance with federal/state regulations. 2) Authorization will expire 365 days from the date signed unless otherwise specified **(Other Date:)**. 3) I have the right to revoke this authorization at any time. Revocation must be made in writing and faxed to 509-826-7678 or mailed to PO Box 793 Omak, WA 98841. Revocation will not apply to information that has already been disclosed in response to this authorization. 4) Any disclosure of information carries with it the potential for unauthorized disclosure, and the information may not be protected by Federal confidentiality rules.

Printed Name of patient/legal representative: Relationship to patient:

Signature of patient/legal representative: Date: Time:

Signature of minor (age 13-17) if requesting sensitive information: