Samaritan Release of Information Department
801 E Wheeler RD, Moses Lake, WA 98837

Phone #: (509) 765-5606 Ext. 1160 or Option 3
*Please call for fax number.

Patient	Patient Name:	Address:
	Date of Birth:	City, State, Zip:
	Other Names Used:	Phone Number:
Authorization	**INFORMATION TO BE RELEASED FROM:**	**INFORMATION TO BE RELEASED TO:**
	Samaritan: ☐ Hospital **OR** ☐ Clinic **OR** ☐ Parkview Pediatrics	☐ Patient (same information as above)
	Provider/ Facility:	Name/ Provider:
	Address:	Address:
	City, State, Zip:	City, State, Zip:
	Phone:	Phone:
	Facility Fax:	Facility Fax*:

Information

Delivery Options: ☐ Mail ☐ Pickup ☐ Fax (Facility only) (*Facility only. We do not fax directly to a patient's personal fax number.)

Purpose of Disclosure: ☐ Continuation of Care ☐ Transfer of Care ☐ Insurance ☐ Personal ☐ Legal ☐ Other: ___________

Notice: I understand that there may be charges associated with my request for records. Records will be made available no later than 15 working days. If the request is denied or the information does not exist or cannot be found, the patient will be notified within 15 working days. (RCW 70.02.080, 70.02.090)

Release the Following Records:	**Dates of Service:**	
☐ Abstract/Summary (includes history and physical, progress notes, consultations & test results)	☐ Date From: _____________	Date To: _______________
☐ Imaging Reports (X-ray, MRI, etc.) ☐ Image cd	☐ Date From: _____________	Date To: _______________
☐ Other Records: _____________________________	☐ Date From: _____________	Date To: _______________

*Billing and Payment records will need to be requested from Patient Financial Services office.

Restrictions

Sensitive Information: I understand that all health care information in my records, including testing and diagnosis for HIV, sexually transmitted diseases, psychiatric disorders/mental health, drug and/or alcohol use will be released unless initialed below.

Do **NOT** send records regarding (check & initial all that apply):

☐ HIV/AIDS _____ ☐ STDs _____ ☐ Psychiatric disorders/mental health _____ ☐ Drug/Alcohol abuse ____

Revocation: I understand that I have the right to revoke this authorization at any time except to the extent that Samaritan Healthcare has taken action in reliance on the authorization. To revoke this authorization, I must submit a written revocation to: Privacy Officer at Samaritan Healthcare, 801 E Wheeler RD, Moses Lake, WA 98837

Expiration: This Authorization ends (Please check ONE of the following options):

☐ in 90 days from the date signed ☐ one year from date signed ☐ other: _________________ (No longer than one year from date signed.)

Disclosure: I understand that Samaritan Healthcare may not condition the Patient's healthcare on this authorization unless (1) the purpose of Samaritan Healthcare's evaluation and treatment is to obtain and disclosure information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research. I understand that information disclosed by Samaritan Healthcare pursuant to this authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations.

Signatures

Patient or legally authorized individual signature:	Date:	Relationship to patient: (self, parent, legal guardian, personal representative)

GUARDIANSHIP PAPERS OR POWER OF ATTORNEY PAPERS ARE REQUIRED

NOTE: If the patient is deceased, only the executor and/or administrator of the estate or next-of-kin may authorize release of copies of medical records. Documentation reflecting such individuals' legal authority to sign for release of records must be provided.

Minor Signature*	Date:

* Signature of minor is also required if minor is age 13-17.RCW 9.02.100 (1), State v. Koome, 84 Wn.2d 901, RCW 70.24.110, RCW 70.96A.095, RCW 71.34.500 & RCW 71.34.530

For Office Use Only:	☐ Driver's License or ID Card Verified	☐ Power of Attorney/ Guardianship Papers on File

FORM: 005221
REVISED: APR 2018

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

*Copy of ID required for verifying signature.
Label: