Authorization for Release of Protected Health Information

Fax Completed Form to (509) 447-7926 or
Mail to: ATTN: H.I.M. Department • Newport Hospital & Health Services • 714 W. Pine St., Newport, WA 99156

Patient Information:

Patient Name_____
Date of Birth:____/____/_____ Address: _____
Month Day Year Street Number and Name
Phone: (____)____-_____ _____
City State Zip Code

Information to be released by: (Please select facility)

☐ **Newport Community Hospital** *714 W. Pine St. Newport, WA 99156*	☐ **Newport Health Center** *714 W. Pine St., Bldg. C Newport, WA 99156*	☐ **River Mountain Village** Assisted Living *608 W. 2nd St. Newport, WA 99156*	☐ **River Mountain Village** Advanced Care *501 W 1st St. Newport, WA 99156*	☐ **Other** Name and location: _____. _____. _____.

Information to be released to:

☐ *Check if recipient is same as patient*
Recipient:_____
Address: _____
Street City State Zip Code
Phone: (____)____-_____ Fax: (____)____-_____

☐ *Check if you would like to access our patient portal* Email: _____
(for hospital or clinic records only) If you checked yes, please leave your email address

Information to be released: (Please select one)

☐ **Most recent 2 years of records** ☐ **All records on file** ☐ **Specific Information** (Please specify, i.e. immunizations, etc.) _____

Purpose for which disclosure is being made: (Please select one)

☐ Legal ☐ Insurance ☐ Ongoing Care ☐ Personal Use

I understand that my medical record may also include information on diagnosis/treatment related to **psychiatric or psychological conditions, drug and/or alcohol abuse, Acquired immunodeficiency syndrome (AIDS) and/or HIV status.** I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

PLEASE INITIAL THE STATEMENT THAT APPLIES
(You must initial one.)

I do_____ do not _____ authorize this information to be released.
Limitations, if any:_____

- I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
- I understand that Newport Hospital & Health Services will not deny treatment or payment based upon whether I sign this authorization.
- I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.
- I understand that I am entitled to a copy of this authorization after I sign it.

Signature of Patient / Legal Representative: _____ Date: _____
Relationship to patient (if other than patient): _____

Signature of witness (if applicable): _____ Date: _____

***You will be required to validate your identity.* This authorization will expire one (1) year from the date of signature.**