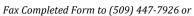
Authorization for Release of Protected Health Information







Patient Information:				
Patient Name				
Date of Birth:/_	/ Addre	Street Number and Na	me	
Phone: ()				
		City		State Zip Code
Information to be rele	eased 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. 2 nd St. Newport, WA 99156	River Mountain Village Advanced Care 501 W 1 st St. Newport, WA 99156	Other Name and location:
Information to be rele	eased to:			
Check if recipient Recipient: Address: Phone: ()	Street		City State	Zip Code
Check if you would		ent portal Email:	If you checked yes, please leave	your email address
Information to be rele	eased: (Please select on	e)		
	All records Sp	ecific Information (Please s	specify, i.e. immunizations, etc.)	
Purpose for which dis	closure is being made:	(Please select one)		
Legal	Insurance	Ongoing C	are Pe	rsonal Use
psychological conditions status. I understand a above may be release PLEA STATEMI	ons, drug and/or alcohond agree that the inform		nodeficiency syndrome (/	AIDS) and/or HIV atment described tion to be released.
disclosure by the recipient at a understand that Newport I understand this authorizate authorization. I understand that I am entitinature of Patient / Legal R	and may no longer be protect Hospital & Health Services wi ion may be revoked in writin led to a copy of this authoriza epresentative:	tected medical records and info ed by federal privacy regulatio Il not deny treatment or paymo g at any time, except to the ext ation after I sign it.	ns. ent based upon whether I sign tent that action has been taker	this authorization.
ature of witness (if applic	able):			Date:

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