# Authorization for Release of Protected Health Information

***Fax completed form to:*** *(509) 897-8597 or* ***Email to:*** *HIM@nhhsqualitycare.org or*
***Mail to:*** ATTN: HIM 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: (check one)**

☐ **Newport Health Center** (509) 447-3139
☐ **Newport Community Hospital** (509) 447-2441
☐ **River Mountain Village** (509) 447-2903
☐ **River Mountain Village Advanced Care** (509) 447-2464
714 W. Pine St. Newport, WA 99156

☐ **Other**
Facility:_____
Address:_____
_____.
Phone:_____Fax:_____

**Information to be RELEASED TO: (check one)**

☐ **Newport Hospital & Health Services**
714 W. Pine St.
Newport, WA 99156
P: (509) 447-2441 F: (509) 897-8597

☐ **Other**
Recipient:_____
Address:_____
Phone:_____Fax:_____

**Information to be released:** (Please select one)

☐ **Most recent 2 years of records**

☐ **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:**_____

☐ *Check if you would like to access to MyChart (our patient portal)* → Email:_____

- 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.**

***Fax completed form to:*** *(509) 897-8597 or* ***Email to:*** *HIM@nhhsqualitycare.org or*
***Mail to:*** ATTN: H.I.M. Department, Newport Hospital & Health Services, 714 W Pine St, Newport, WA 99156