

OCEAN BEACH HOSPITAL

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name: _____
 DOB: ____/____/____
 Information to be released to:
 Name: _____
 Address: _____

 Phone: (____) ____-____.

Medical Record # _____
 Stay # _____
 Information released from:
Ocean Beach Hospital
174 First Avenue, North
P.O. Box H
Ilwaco, WA. 98624
 Phone: 360-642-3181 ext. 6356
 Fax: 360-642-8070

Purpose for release of information (please check one):

- Further care Self Third party payer Legal purpose Other _____

Type of record:	Date of Service	From	To
<input type="checkbox"/> Laboratory Results:		_____	_____
<input type="checkbox"/> Radiology Report/Film:		_____	_____
<input type="checkbox"/> ER Records/In-patient Record:		_____	_____
<input type="checkbox"/> Other Records (Specify):		_____	_____

Consent of a Minor: A minor patient's signature is required in order to release information concerning care for: (1) conditions relating to the minors sexuality including, but not limited to, contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted disease; (2) alcoholism or drug abuse; and (3) mental health conditions. Age fourteen (14) and above for drug and/or alcohol related information or information related to sexuality; age thirteen (13) or above for mental health information.

Special Authorization: Records containing information relating to drug, alcohol, mental health, and sexually transmitted disease testing, diagnosis, and treatment or history require special authorization (please see regulatory information listed on the opposite side)

PLEASE INITIAL BELOW AS IT APPLIES:	Date of Service	From	To
____ Drug abuse history, diagnosis, and/or treatment		_____	_____
____ Alcoholism history, diagnosis, and/or treatment		_____	_____
____ Mental Health history, diagnosis, and/or treatment		_____	_____
____ Sexually transmitted disease history, diagnosis and/or treatment		_____	_____

This authorization is valid until _____ (Expiration date or Event) or for one (1) year, whichever is earlier. This must be filled out for this authorization to be valid. This authorization may be revoked *in writing* at any time.

I hereby authorize the release of the medical records specified above. This includes Special Authorization, if indicated above. I understand that once this information has been disclosed, it may no longer be protected by privacy laws and may be subject to redisclosure.

____/____/____
Date

Signature of patient or legally responsible party authorizing release of information.

Printed Name if signed on behalf of the patient.

Relationship
(Parent, legal guardian, personal representative)

- ★ There may be charges associated with your request for records ★
 ★ Identification will be required before releasing information ★

Authorization for Release of Medical Information

Drug and alcohol abuse treatment information:

Federal regulations (42 CFR, part 2) prohibit any further disclosure of this information except with specific written consent of the person to whom the information pertains or as otherwise permitted by federal law. A general authorization for the release of information is not sufficient for this purpose. Federal regulations state that any person who violates any provision of the law shall be fined not more than \$500.00 in the case of a first offense and not more than \$5,000.00 in the case of each subsequent offense.

Sexually transmitted disease information:

State law prohibits any further disclosure of this information without specific written consent of the person to whom the information pertains, or as otherwise permitted by state law. A general authorization to release information is not sufficient for this purpose. Any violation of the law is a gross misdemeanor, and the law creates civil remedies for any violation, which includes a \$1,000.00 fine for a negligent violation, and a \$2,000.00 fine for an intentional or reckless violation, actual damages, and attorney's fees.

List information released (labs, reports, dates of service, etc.)

(For Office Use Only)

Authorization to release patient medical information

Patient pickup Mailed Faxed

_____/_____/_____
Date

Signature of hospital personnel authorizing the release of information

Information released by:

Signature of person releasing information

_____/_____/_____
Date