RELEASE OF INFORMATION – OCEAN BEACH HOSPITAL & MEDICAL CLINICS

Health Information Management

174 1st Ave N/PO Box H, Ilwaco, WA 98624
Ph: 360-642-6356 Fax: 360-412-6484

Last Name	First	Middle	Date of Birth
Mailing Address			Daytime Phone
City, State, Zip			Evening Phone

☐ **I request that Ocean Beach Hospital and Medical Clinics provide me with a copy of my health information as follows:**

☐ **I request that the following facility/provider release a copy of my health information as follows:**

Facility/Provider____

Which dates of service?	☐ Specific: From______________ To________________ ☐ One-Year History ☐ Other: ____
What information are you requesting?	☐ Clinical Summary (Provider documentation, medication list and diagnostic information: Lab, Radiology, EKG, etc.) ☐ Radiology Images (Disk) ☐ Other (specify):____
How do you want it delivered?	☐ Pick up in person *Only yourself or a Designated Representative ☐ Mail to the above address ☐ MyChart:____ ☐ Other:____
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 initial the following as they apply: _____:Drug/Alcohol history, diagnosis, and/or treatment _____:Mental Health history, diagnosis, and/or treatment _____:Sexually Transmitted Disease history, diagnosis, and/or treatment

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.

This authorization expires one year from the date of signing unless revoked or otherwise specified: ____________________
Date

____ ____________________
Signature of Patient or Parent/Guardian/Authorized Representative **Date**

____
Relationship to Patient

Revised 01/21/2021

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How to request a copy of your medical record:

- Complete the attached **Authorization for Release of Protected Health Information** form and mail or deliver to Ocean Beach Hospital
- Please be sure to include a complete address and a phone number where we can reach you, in case we have any questions about your request
- If a parent, guardian, or an authorized personal representative is signing this form, please include your relationship to the patient on the line provided

IF YOU HAVE A CURRENT RELEASE ON FILE YOUR RECORDS WILL NOT BE AUTOMATICALLY RELEASED, YOU MUST CONTACT THE HIM DEPARTMENT (360-642-6356) AND REQUEST THE RECORDS BE PREPARED

What to expect:

- **Authorization for Release of Protected Health Information** is good for one year unless otherwise stated
- Your request will be processed within 15 business days once it is received by the Health Information Department
- If you are requesting records for a provider, we may be able to expedite the release process for continuity of care by having the requesting provider fax a request directly to the HIM department at 360-412-6484
- Your authorization may be cancelled in writing at any time. A cancellation will not change releases that happen before the cancellation
- This release is only good for Ocean Beach Hospital and Medical Clinics
- Photo ID required when picking up requested records

***Designating a Representative:**
If you want a person besides yourself to have access to request and/or pick up copies of your medical records you will need to complete the **Designated Representative Authorization Form**.

- This form must be completed by the patient and witnessed by Ocean Beach Hospital staff for it to be valid.
- Once the form is complete it is valid for 1 year unless otherwise documented on form
- Your authorization may be cancelled in writing at any time. A cancellation will not change releases that happen before the cancellation
- The Authorized Representative will be required to provide ID when obtaining any records on the patients behalf

Consent of a Minor:
A minor patient's signature is required in order to release information pertaining to following conditions:

- Any Age: Contraception, sterilization, pregnancy, and pregnancy termination
- Age 14 and above: Sexually transmitted disease testing and treatment
- Age 13 or above: Mental Health Information & Alcoholism or drug abuse

Contact Information:

Ocean Beach Hospital and Medical Clinics
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Fax: 360-412-6484

Have you heard about MyChart?

MyChart is a free service that gives you secure online access to your medical information. For more information about MyChart go to https://orca.myonlinechart.org or ask our staff to help get you signed up.