East Adams Rural Healthcare
903 South Adams, Ritzville, WA 99169
Phone: 509-659-1200, ext. 309 Fax: 509-659-1113

AUTHORIZATION FOR EARH TO OBTAIN OR DISCLOSE MY HEALTH CARE INFORMATION

***required fields – Incomplete forms cannot be processed**

*Patient Name: _____ *Date of Birth: _____

*Address: _____Social Security Number: _____

*Daytime phone: _____ Records needed by: _____

☐ **I authorize East Adams Rural Healthcare: ☐ Release information to; ☐ Obtain From (must be filled out completely):**
***By (must choose one): ☐ Fax ☐ Mail ☐ Disc ☐ Pick-Up at facility**

_____ _____ _____
*Name/Facility and/or Provider *Phone Number *Fax Number

_____ _____ _____ _____
*Address *City *State *Zip

***Records needed By:** ☐ Stat ☐ For an appointment on: _____

***You may use or disclose the following healthcare information (mark all that apply):**
☐ Verbal Only ☐ Records Only ☐ Verbal and Records ☐ Appointment Info Only

1. My Authorization

You may use or disclose the following health care information (check all that apply):

- ☐ All health care information in my medical record for the past **☐ 1 Year ☐ 2 Years ☐ 5 years** for (choose one):
  - ○ Ritzville Medical Clinic/Washtucna Medical Clinic (clinic services only)
  - ○ East Adams Rural Healthcare (hospital services only)
  - ○ Both Clinic and Hospital Services
- ☐ Billing Records
- ☐ Health care information in my medical record(s) relating to the following treatment or condition: _____
- ☐ Health care information in my medical record for date(s) of service (must have date(s)):_____

a. Sensitive information

I understand that my medical record may include information on a diagnosis/treatment related to psychiatric, psychological or mental health conditions, drug or alcohol use or abuse, sexually transmitted infections (STI), acquired immune deficiency syndrome (AIDS), and or HIV status and genetic testing.

I consent for the following information to be disclosed (mark any/all that apply):_____ (initial)

☐ Drug and/or alcohol use ☐ Psychiatric disorder/mental health ☐ HIV (AIDS virus) ☐ Sexually Transmitted Infections (STI)

b. **Reason for Authorization (check one):** ☐ At the request of the individual ☐ Other: _____

c. **This authorization ends (check one):**

☐ 90 Days from the Date of the Signature ☐ On (date): _____ ☐ Event (one time release): _____

2. **My Rights**

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment) However, I do have to sign an authorization form for:

a. To take part in research study; or
b. To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by East Adams Rural Healthcare based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization is to: Fill out a revocation form, available from East Adams Rural Healthcare, or to write a letter to East Adams Rural Healthcare. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or Legal Representative: _____ Date: _____

Relationship to Patient: _____ Witness Signature: _____

EARH Use Only: ☐ Patient provided records at time of service (i.e. lab results). Completed By: _____ (staff initials)

Received in HIM (date): _____ Completed By (initial): _____ Date: _____ ☐ Records picked up (date):_____ Staff initial: _____