AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

PATIENT MEDICAL INFORMATION REQUESTED:

Patient Name: ____________________
Date of Birth: ____________________
Account #: ____________________
Email Address:

INFORMATION RELEASED FROM:

Name: ____________________
Relationship: ____________________
Address: ____________________
City, State, Zip: ____________________
Phone: ____________________
Fax:

INFORMATION RELEASED TO:

Name: ____________________
Relationship: ____________________
Address: ____________________
City, State, Zip: ____________________
Phone: ____________________
Fax:

GENERAL MEDICAL INFORMATION REQUESTED TO BE RELEASED (PLEASE SELECT ALL THAT APPLY)

☐ Allergy List	☐ Immunization Records	☐ Operation Reports	☐ Special Studies
☐ Billing Summary	☐ Laboratory Data	☐ Orders	☐ Vitals
☐ Clinical Notes	☐ Letters	☐ Pathology Reports	☐ X-Ray Results
☐ EEG, EKG	☐ Medication List	☐ Problem List	

☐ OTHER: (Please Explain) ____________________

Please specify desired date range for medical records reporting period or circle time frame below

Last 1 year   Last 2 years   Last 3 years   **O R**   From: / /   TO: / /

★ ____________________ *Signature of Patient or Authorized Representative*   ____________________ *Relationship to Patient if NOT Patient*   / / *Today's Date*

PURPOSE FOR TRANSFERRING MEDICAL INFORMATION (PLEASE SELECT ALL THAT APPLY)

☐ Referring to Another Provider   ☐ Moving Out of Area. *Where?* ____________________
☐ Legal   ☐ VFH Does Not Accept My Insurance. *Company?* ____________________
☐ Transferring Medical Care   ☐ Dissatisfied With Care *(Please Explain Below)*
☐ For Insurance Claim   ☐ Share Info with Spouse, Parent, Child, etc.   ☐ Other *(Please Explain Below)*

AUTHORIZATION EXPIRES 1 YEAR FROM DATE SIGNED, UPON MINOR'S AGE OF MAJORITY, OR UPON TERMINATION OF HEALTH PLAN.

FEDERAL LAW REQUIRES YOU TO INITIAL EACH ITEM TO AUTHORIZE RELEASE.

★
________ Physical Abuse	________ Drug & Alcohol History	________ Sexually Transmitted Disease
________ HIV / AIDS Information	________ Mental & Psychiatric Health	________ Reproductive Care (Minors Only)

MINORS—A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to; contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

★ ____________________ *Signature of Patient, Minor or Authorized Representative*   ____________________ *Relationship to Patient if NOT Patient*   / / *Today's Date*

★ ________ I am aware a clerical fee for compiling records of $24, and a per-page fee of $1.09 for the first 30 pages MAY apply (.82¢ per page 31 and greater). I understand a VFH staff member will contact me with the total charge before I am billed.

TO BE COMPLETED BY VISTA FAMILY HEALTH MEDICAL RECORDS DEPARTMENT

/ /	/ /	$	☐ Yes ☐ No	
Date Received	Date Completed	Charge	Paid?	Collected By

VISTA FAMILY HEALTH **Phone:** (509) 735-2325 **Fax**: (509) 735-3222 **Address**: 7201 W. Grandridge Blvd., Suite 101, Kennewick, WA 99336