AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Trios™ Health

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
- ☐ Billing Summary
- ☐ Clinical Notes
- ☐ EEG, EKG
- ☐ Immunization Records
- ☐ Laboratory Data
- ☐ Letters
- ☐ Medication List
- ☐ Operation Reports
- ☐ Orders
- ☐ Pathology Reports
- ☐ Problem List
- ☐ Special Studies
- ☐ Vitals
- ☐ X-Ray Results
- ☐ 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
- ☐ Legal
- ☐ Transferring Medical Care
- ☐ For Insurance Claim
- ☐ Moving Out of Area. *Where?* _____
- ☐ VFH Does Not Accept My Insurance. *Company?* _____
- ☐ Dissatisfied With Care *(Please Explain Below)*
- ☐ 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
_____ HIV / AIDS Information
_____ Drug & Alcohol History
_____ Mental & Psychiatric Health
_____ Sexually Transmitted Disease
_____ 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