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All portions of this form **must** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Medical Record # \_\_\_\_\_

Address \_\_\_\_\_ Telephone No. \_\_\_\_\_

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information \_\_\_\_\_

Agency or Individual(s) Authorized to Receive my Health Information \_\_\_\_\_

Address \_\_\_\_\_

Health Information that may be used / disclosed is limited to the following:  Progress Notes  Emergency Room Record  
 Discharge Summary  History & Physical  Consultation(s)  Lab  Pathology Report  
 Operative Note(s)  Imaging/X-ray  X-ray Reports  Entire Record  Other (specify) \_\_\_\_\_

Health Information that may be used / disclosed is limited to the following periods of healthcare:  
From (date): \_\_\_\_\_ To (date): \_\_\_\_\_ Account Number: \_\_\_\_\_  
From (date): \_\_\_\_\_ To (date): \_\_\_\_\_ Account Number: \_\_\_\_\_

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):  
 Treatment/Consultation  At Request of Patient  Research  Marketing  Billing or Claims Payment  
 Other \_\_\_\_\_

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, **to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

If applicable, I agree to the release of my medical or billing records containing the **sensitive information** listed above.  Yes  No

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically **expire 60 days** after the date of signature below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature\* \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Relationship to Patient / Authority to Act on Patient's Behalf \_\_\_\_\_ Interpreter, if Utilized \_\_\_\_\_

Witness's Signature \_\_\_\_\_ Expiration Date or Event \_\_\_\_\_

\*Signature must be validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.

Authorization to Use and Disclose Protected Health Information

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WHITE - Medical Record CANARY - Recipient

Patient Label

**Notice to Patients  
Photocopy Charges for Medical Records**

We will be happy to provide copies of your medical records per your request. Deaconess Hospital contracts with IOD Incorporated, 100 116<sup>th</sup> Ave SE, Bellevue, WA 98004 (877) 328-7344, a professional medical record copying service, to ensure that your copies are available to you as quickly as possible.

Prior to copying your records, IOD incorporated, would like you to know that there is a charge for this service and prepayment is required.

**1-9 pages = No charge  
10-30 pages = 1.04 per page  
31 + pages = .79 per page  
Postage and tax (8.7%) will be changed when applicable.**

The charge for the copying of medical records, is to cover the costs of labor and supplies, has been developed by the Washington State Legislature and is outlined in RCW 70.02.

IOD Incorporated will contact you with the prepayment amount. Medical records will not be copied until prepayment is received.

Please complete **BOTH** pages of this form and mail to:

Deaconess Hospital  
Attn: Medical Records  
PO Box 248  
Spokane, WA 99210  
(509) 473-7421

I understand that there is a charge to copy my medical records and that IOD Incorporated requires prepayment. IOD Incorporated will notify me of the charge and when they receive prepayment in full, my records will be copied.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone Number \_\_\_\_\_

800 W. 5<sup>th</sup> Ave, PO Box 248, Spokane Washington 99210 (509) 473-7421 Fax (509) 473-3075