HealthWay

WASHINGTON COUNTY MEMORIAL HOSPITAL

Office Use Only: Electronic __ Paper__ Both___

Authorization for Release of Medical Information

Patient name: _____ Date of Birth: _____

Address: _____

Patient phone #: (_____)_____ Date of request _____ Date Processed _____
Authorize Electronic Release Of Records:_____Yes _____No _____ Personal email address delivery ONLY

Email Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

☐ I authorize WCMH - RHC **to release information to**:	**OR**	☐ I authorize the WCMH - RHC **to obtain information from**:
_____ Name of Provider or Facility		_____ Name of Provider or Facility
_____ Address		_____ Address
_____ City, State, Zip Code		_____ City, State, Zip Code
_____ Phone #/Fax # (include area code)		_____ Phone #/Fax # (include area code)

1. **PURPOSE FOR THIS REQUEST: ( )** Transfer of Care **( )** Moving **( )** Personal **( )** School **( )** Legal **( )** Other (specify) _____
2. **TYPE OF RECORDS REQUESTED:**
   ( ) Immunization record **( )** Social Security/Disability Request **( )** Insurance Form **( )**Verification of status/diagnosis **( )** Laboratory test results _____ (please indicate date or test) **( )** Last one year of medical records **( )** Last two years of medical records **( )** Copy of all medical records **( )** Letter regarding treatment (please describe) _____**( )** Other (Please describe.) _____
3. **** IF your medical record contains any of the following sensitive information, WCMH-RHC will only release these records if you INITIAL authorization next to the type of information listed below: HIV information_____ Mental/Behavioral health information_____**
4. **Records should be ( )** Mailed to my home address **( )** Mailed to agency above **( )** Left at WCMH-RHC for pick up
5. **Expiration Date of Request _____, If not completed this authorization expires 90 days after it is signed.**

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- This authorization is valid for this release only.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- I understand that once information is released, used and/or shared, the person or organization that receives it may share it again. If this happens, the information may no longer be protected under applicable privacy laws.
- I understand the type of information that is being released, used and/or shared and how this will be done
- Release of HIV-related and mental/behavioral health/substance abuse information and treatment is highly sensitive and requires additional authorization (by initialing above).
- **There may be a charge for the requested records**.

Medical records are only faxed in cases of medical necessity.

Signature of Patient or Representative: _____Date: _____
Relationship to Patient *(if requester is not the patient):* _____

WCMH-RHCs understands the importance of your request and strives to process your request as soon as possible; however due to the number of requests WCMH-RHCs receives daily, requests are processed in the order in which they are received. Please let us know if the requested information is needed by a specific date and every effort will be made to meet your needs. **WCMH- RHCs complies with HIPAA regulations which require processing of requests for medical information within 30 business days of request.** **-AND-**

- I understand that I may revoke this authorization at any time unless the Clinic has already taken action based on this form (or unless this authorization is given as a condition of obtaining insurance coverage and the insurer has certain legal rights to contest the policy or a claim under the policy).
- If I revoke this authorization, I must do so in writing.
- Additional information regarding the procedure for revoking this authorization will be in clinic's Notice of Privacy Practices, once available.
- I understand that I may refuse to sign this authorization. I also understand that the Clinic will not deny treatment because I refuse to sign this authorization.
- I understand that information disclosed based on this authorization may be redisclosed by the entity or the person who receives the information. Once disclosed, it is possible that the information will no longer be protected under federal medical privacy law.
- The use or disclosure of the requested information may result in direct or indirect payment to WCMH-RHCs from a third-party, including copying fees.
- I may inspect or copy the protected health information to be used or disclosed subject to the discretion of my provider and as will be outlined in WCMH- RHCs clinic's Policy for Right of Access to Protected Health Information, when available.
- The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act. Disclosures may only be made pursuant to a valid authorization by the client or as provided in Title III or IV of that Act. The Act provides for civil damages and criminal penalties for violations (D.C. Code § 6-2004 (1995)).
- If the records or information being released involve treatment for alcohol or substance addiction, my records are also protected by federal law and regulations relating to "confidentiality of alcohol or drug abuse patient records." (42 C.F.R. Part 2, 42 U.S.C. § 290dd-2).
- If the records or information released involve treatment for alcohol or substance addiction, this information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Witness:_____ Date: _____