I request and authorize the use or disclosure of the above named individual’s health information as described below.

**Release Method (check one):  ____ Paper  ____ Fax  ____CD  ____ Flash Drive ($5 fee)**

**TYPE OF INFORMATION TO BE RELEASED:**

Purpose or need for this information is: ________________________________

<table>
<thead>
<tr>
<th>TYPE OF INFORMATION</th>
<th>DATES OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ All Medical Records (limited to two (2) years of information unless otherwise stated; excluding federally protected information)</td>
<td></td>
</tr>
<tr>
<td>□ Discharge Summary</td>
<td>From ______ To ______</td>
</tr>
<tr>
<td>□ History &amp; Physical</td>
<td>From ______ To ______</td>
</tr>
<tr>
<td>□ Lab Results (Specify)</td>
<td>From ______ To ______</td>
</tr>
<tr>
<td>□ Operative Report</td>
<td>From ______ To ______</td>
</tr>
<tr>
<td>□ X-Ray or other Diagnostic Reports</td>
<td>From ______ To ______</td>
</tr>
<tr>
<td>□ Consultation Report</td>
<td>From ______ To ______</td>
</tr>
<tr>
<td>□ Release to Return to Work</td>
<td>From ______ To ______</td>
</tr>
<tr>
<td>□ Other Reports (Specify)</td>
<td>From ______ To ______</td>
</tr>
</tbody>
</table>

**INFORMATION PROTECTED BY STATE/FEDERAL LAW:**

I understand that a general authorization is not enough to release health care information relating to the testing, diagnosis and or treatment of the following:

Mental Health/Psychiatric, Alcoholism/chemical dependency and Sexually transmitted diseases, (including HIV/AIDS test results). My express authorization is required below.

- Mental Health/Psychiatric – RCW 71.05.390 – RCW 71.05.440
- Alcoholism/chemical dependency – Federal Regulations (42 CFR part 2)
- Sexually Transmitted Diseases records includes AIDS/HIV – RCW 70.24.105, WAC 248-100-016
CONSENT OF MINOR (age 14 and above for Drug and Alcohol, and Sexually Transmitted Disease information, including HIV/AIDS; 13 and above for Mental Health Information)
A minor patient’s signature is required in order to release information concerning care for:
1. Pregnancy termination and sexually transmitted diseases
2. Alcohol or drug abuse
3. Mental health conditions

ADDITIONAL INFORMATION REGARDING YOUR REQUEST
Dear Patient:

Kadlec Health System provides the searching, copying and billing for release of information requests. If charges occur, please make checks payable to Kadlec Regional Medical Center.

Records 2002 and older will have a separate fee.

Please request charge sheet. Call (509-942-2017)

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department of Kadlec Health System. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 90 days from the date signed below. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Director.

__________________________________________________ ______________________________
Signature of Patient or Legal Representative   Date

__________________________________________________
Relationship to Patient if not Patient

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ENROLL TODAY for My K-Chart -To securely access the online My K-Chart medical record (which has limited information) go to: http://www.mykchart.org
If you have questions or issues accessing My K-Chart, email kchart@kadlec.org or call 509-942-2017.

Form # 2128