KADLEC Health System
888 SWIFT BOULEVARD
RICHLAND, WASHINGTON 99352
Health Information Management: 509-942-2017
Fax 509- 942-2701

Patient Information: Please print

*Patient Name: _____ Date of Birth:_____

Former Name (if any): _____ Phone Number:_____

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

From: (where records currently are)	To: (where records are going)
*Facility/Doctor: _____	*Facility/Doctor/patient_____
Address: _____	Address: _____
City:_____ State: _____ Zip: _____	City:_____ State: ____ Zip:_____
*Phone: _____*Fax: _____	*Phone:_____ *Fax:_____

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

TYPE OF INFORMATION TO BE RELEASED:

Purpose or need for this information is: _____

TYPE OF INFORMATON	DATES OF SERVICE
☐ All Medical Records **(limited to two (2) years of information unless otherwise stated; excluding federally protected information)**	
☐ Discharge Summary_____	From_____ To_____
☐ History & Physical_____	From_____ To_____
☐ Lab Results (Specify)_____	From_____ To_____
☐ Operative Report_____	From_____ To_____
☐ X-Ray or other Diagnostic Reports_____	From_____ To_____
☐ Consultation Report_____	From_____ To_____
☐ Release to Return to Work_____	From_____ To_____
☐ Other Reports (Specify)_____	From_____ To_____

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

888 SWIFT BOULEVARD
RICHLAND, WASHINGTON 99352
Health Information Management: 509-942-2017
Fax 509- 942-2701

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)

- -

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

- -

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.