BETHANY
OF THE NORTHWEST

Authorization to Release Medical Records

PATIENT INFORMATION

Name (print) *Please include maiden or other name if applicable. DOB SSN

_____ _____ _____

INFORMATION TO BE RELEASED FROM

Name of facility or provider

_____

Address City State Zip

_____

INFORMATION TO BE SENT TO

Name of designated recipient

_____ Fax number:_____

Address City State Zip

_____

INFORMATION TO BE RELEASED

_____ The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)

_____ All medical records (including intake forms, medical billing, patient questionnaires, physician notes, referral faxes etc.)

_____ All medical records from _____ to _____.

_____ Specific information (please specify) _____

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (PLEASE CHECK ONE)

☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal

PATIENT AUTHORIZATION

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records released (please initial)

_____ Drug/Alcohol abuse, treatment and diagnosis.

_____ HIV/AIDS diagnosis, treatment and testing.

_____ Sexually transmitted disease.

_____ Mental illness or psychiatric Diagnosis and treatment.

MY RIGHTS

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. Patient or Personal Representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Free disclaimer: Federal and state laws permit Bethany to charge a reasonable fee for copying/releasing records. State regulated fees for labor and supplies may apply. You will be notified directly regarding any fees and payment as required. If patient will not be paying invoice of reasonable costs, who does the patient authorize Bethany to contact for payment?

Name _____ Relationship _____
Email _____ Phone _____
Address _____ Fax _____

Signature _____ Date _____
(Patient, guardian, or authorized representative)

Relationship and authority to sign (Power of Attorney, Guardian etc.) if signed by representative:

_____

***Note: Requests can take up to 15 business days to process. Please indicate urgency when necessary.**

This authorization will expire 90 days from the date signed.
Possible copying fee required.

Please mail this completed and signed form to PO Box 13700, Mill Creek WA 98082
or
Fax to the patient's Bethany facility at the fax number listed below.

Silver Lake	Silver Crest	Pacific	ETCS	Home Health
425.328.1626	425.689.1279	425.412.6275	425.645.6412	425.526.5842

If you have questions regarding your request, please contact your patient's specific Bethany facility to inquire.

(Please allow 48 hours for your request to be received and entered into our system before calling).