Wenatchee Pain Relief

636 Valley Mall Pkwy Suite 5
East Wenatchee WA 98802
Phone: 509-888-3496
Fax: 509-888-7428

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

A. PATIENT INFORMATION

PATIENT NAME: _____ **PATIENT DATE OF BIRTH:** _____

PATIENT ADDRESS STREET: _____

_____ **APT.#:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

TELEPHONE CONTACT#:( ) _____ **EMAIL:** _____

B. PERMISSION TO SHARE: I give my permission to share my protected health information.

From:

Name: _____

Address: _____

_____

Telephone Number: _____

To:

Name: Dr. Jared Wagner

Address: 636 Valley Mall Pkwy Suite 5

East Wenatchee WA 98802

Telephone Number: 509-888-3496

Fax Number: 509-888-7428

Send by:

☐ Fax
☐ Mail
☐ Electronically (secure email)
Email Address: _____

Purpose (check the appropriate box)

☐ Medical Care ☐ Other (please specify)*
☐ Insurance*
☐ Legal Matter*
☐ Personal*
☐ School * Copying fees may apply

C. INFORMATION TO BE RELEASED (Please check all that apply, and specify dates):

☐ Medical Record Abstract/dates
(e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)

☒ Clinic Visit Notes/dates Last 3 Visits Notes

☐ Discharge Summary/dates _____

☐ Lab Reports/dates _____

☐ Operative Reports/dates _____

☐ Pathology Reports/dates _____

☐ Radiation Reports/dates _____

☒ Radidogy Reports/dates Imaging Reports Last 3 Years

☐ Photographs/dates (costs may apply) _____

☐ Billing Records/dates _____

☐ Other ***(please specify below and include dates)***

_____

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D. Please check YES to indcate if you give permission to release the following information if present in your record:

- ☐ Yes — HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.) SPECIFY DATES
- ☐ Yes — Genetic Screening test results (SPECIFY TYPE OF TEST)
- ☒ Yes — Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSI_Y PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR ftS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon oral or written request
- ☐ Yes — Other(s): Please List
- ☒ Yes — Details of Mental Health Diagnosis anc:1/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) *(I understand that my permission may* not *be required* b *release my mental health records for payment purposes)*
- ☐ Yes — Confidential Communications with a Licensed Social Worker
- ☐ Yes — Details of Domestic Violence Victims' Counseling
- ☐ Yes — Details of Sexual Assault Counseling

E. I understand and agree that:

- This authorization is voluntary.
- My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form.
- I may cancel this authorization at any time by submitting a written request
  This authorization will automatically expire 6 months from the date signed unless otherwise specified.
- My questions about this authorization form have been answered.

➢ **Patient's Signature:** _____ ➢ **Date:** _____

➢ **Print Name:** _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ **Date:** _____

Print Name: _____ **Relationship of representative to patient:** _____