



# Medical Records Release Form

CHAS Health Attn: Health Records  
1502 N Vercler Rd, Spokane WA 99216  
Phone: 509-434-0381 Fax: 509-434-0392

Authorization for CHAS Health to Obtain or Disclose My Health Care Information

**\*\*Required**

**\*\*Patient Name\*\***: \_\_\_\_\_ **\*\*Date of Birth\*\***: \_\_\_\_\_  
Previous Name: \_\_\_\_\_ **\*\*Daytime Phone\*\***: \_\_\_\_\_  
Date Records Needed By: \_\_\_\_\_

**\*\*Please check\*\*** If both boxes are checked CHAS staff will release records as specified as well as fax the request to the location listed.

I request and authorize CHAS to:  Release To  Obtain From

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**\*\*You may use or disclose the following health care information** (mark all that apply):

- Verbal Release (please specify what can be disclosed):  appointment info. only
- Dental:  Records  X-rays
- Chart notes
- Lab Reports
- X-ray/Diagnostic Reports
- Medication List
- All health care information does not include sensitive information, please see below (includes 2yrs, unless specified)
- OB Records
- Billing Records
- Immunizations
- Other: \_\_\_\_\_

**I understand that my medical record may include information on the diagnosis/treatment related to psychiatric, psychological or mental conditions, drug and or alcohol use or abuse, sexually transmitted infections (STI), acquired immune deficiency syndrome (AIDS), and or HIV status and genetic testing.**

I consent for the following information to be disclosed: (mark any/all that apply):

\_\_\_\_ HIV (AIDS virus) \_\_\_\_\_ Sexually transmitted infections  
\_\_\_\_ Psychiatric disorder/mental health \_\_\_\_\_ Drug and/or alcohol use

**\*\*Reason for Authorization:**  At the request of the individual;  Other: \_\_\_\_\_

**\*\*Expiration:**  Date : \_\_\_\_\_ OR  Event (one time release): \_\_\_\_\_  
MM/DD/YYYY

**If date is not specified, this request will expire in 90 days from the date of signature.**

If the release is for the patient's **EMPLOYER** or **FINANCIAL INSTITUTION** for reasons other than payment, this authorization will remain valid for **only 90 days**. Patient may revoke this authorization at any time prior to expiration by notifying CHAS in writing.

The information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by federal law. State and federal law specifically requires that any patient medical record and/or personal health care information containing drug and alcohol diagnosis and treatment, mental health and sexually transmitted infections, including HIV/AIDS are privileged and confidential and may only be disclosed by express authorization, except as required by law. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2 and Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may refuse to sign this authorization. CHAS may not condition treatment, payment, enrollment or eligibility on the authorization of this release.

\_\_\_\_\_  
**\*\*Signature/Legally Responsible Party**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**\*\*Date**

A minor's signature alone is sufficient to release health care information related to (1) sexually transmitted diseases, including HIV/AIDS (age 14+), (2) alcohol and/or drug abuse (age 13+ (Idaho is 16+)), (3) mental health information (age 13+ (Idaho is 14+)), (4) birth control services (WA only), (5) abortion services (WA only), and (6) prenatal care services (WA only).

\_\_\_\_\_  
**Signature of Minor Patient**

\_\_\_\_\_  
**Date**