QUINCY VALLEY MEDICAL CENTER

☐ Verification of identity/Authority Attached
Identification Required for Authentication:
Driver's license, photo ID, power of attorney, warrant, subpoena or other legal process.

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

(Authorization VOID if not completely filled out)

## PATIENT INFORMATION:

Printed Name of Patient _____ Previous Names, If Applicable _____

Address _____ E-mail: _____

Date of Birth _____ Phone Number _____

## SEND INFORMATION TO: (Be Specific)

Provider Name/Organization _____ Name of Receiving Person _____

Address _____

Phone Number _____ Fax Number _____

## INFORMATION TO BE RELEASED FROM: (Be Specific)

Provider Name/Organization _____

Address _____

Phone Number _____ Fax Number _____

Purpose of Disclosure: ☐ Transfer of Care ☐ Self ☐ Specialist ☐ Other: _____

## INFORMATION TO BE DISCLOSED:

☐ Medical Records from Last 2 Years ☐ Complete Designated Record Set
☐ Summary Health Information ☐ Other: _____

Date of Service _____ Expiration Date (or event) _____

## SENSITIVE INFORMATION:

This authorization includes the release of the following sensitive information unless specifically excluded. Please check if you DO NOT want this released.

☐ Mental Health/Psychiatric Disorders ☐ Drug, Alcohol Abuse/Treatment ☐ Reproductive care (minors only)
☐ HIV/AIDS Virus ☐ Sexually Transmitted Diseases ☐ Other: _____

- If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient.
- This form will be active for 90 days upon receipt or 30 days for special consents below and may be revoked at any time on form 3(c), Authorization Revocation, proving the information has not already been disclosed. Upon receipt of this authorization, Quincy Valley Family Clinic has 15 days to comply with your request and will charge reasonable cost-based fee for each disclosure within a given year.
- We will not condition treatment on the completion of the authorization. Please be aware that once we disclose this information per your instructions the information is subject tore-disclosure.

**Date** _____ **Signature of Patient or Representative** _____ **Relationship to Patient** _____

PLEASE NOTE: For patients requesting copies of personal or dependent records, the first 25 pages will be provided at no cost; additional pages will be subject to costs reflected below:

26 to 55 pages: $1.17 per page
56 pages or more: $0.88 per page

If your request is over 25 pages our Medical Records department will send an invoice to the e-mail specified under 'Patient Information' above.You can pay in person at our facility or over the phone at 1-509-787-5391.


908 10th Avenue SW, Quincy, WA 98848 Phone: 509.787.3531 Fax: 509.787.8708 