**AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION**

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| --- | --- |
| Name and address of health care provider:  □ PeaceHealth Southwest Medical Center  400 NE Mother Joseph Place  P.O. Box 1600  Vancouver, WA 98668-1600  □ Hood River Memorial Hospital  810 12th Street  Hood River, OR 97**031**  □ Legacy Salmon Creek  2211 NE 139th Street  Vancouver, WA 98686  □ Skyline Hospital  211 NE Skyline Drive  White Salmon, WA 98672 | To use/disclose medical information to:  □ Skamania County Sheriff’s Office  P.O. Box 790  Stevenson, WA 98648  □ Klickitat County Sheriff’s Office  205 S. Columbus Ave, #7  Goldendale, WA 98620  □ Bingen/White Salmon Police Department  P.O. Box 2139  White Salmon, WA 98672  □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose: CRIMINAL INVESTIGATION Date of hospitalization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By **INITIALING** the space(s) below, I specifically authorize the use and/or disclosure of the following information and/or medical records, if such information and/or records exist:

* Specify below **(PLEASE INITIAL)**:

\_\_\_\_\_\_ Clinician office chart notes \_\_\_\_\_\_ Laboratory reports

\_\_\_\_\_\_ Transcribed hospital reports \_\_\_\_\_\_ Pathology reports

\_\_\_\_\_\_ Most recent five-year history \_\_\_\_\_\_ Diagnostic imaging reports

\_\_\_\_\_\_ Emergency and urgent care records \_\_\_\_\_\_ Billing statements

\_\_\_\_\_\_ Photographs and videotapes \_\_\_\_\_\_ Dental records

\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Please send the **entire medical record (all information)** to the above named recipient. **\_\_\_\_\_\_\_\_\_\_\_\_\_ (PLEASE INITIAL)**

The following items must be **initialed** **for them to be excluded** in the use and/or disclosure of other medical information:

\_\_\_\_\_\_\_ \* HIV/AIDS test or result information and/or records

\_\_\_\_\_\_\_ \* Mental health information and/or records

\_\_\_\_\_\_\_ \* Genetic testing information and/or records

\_\_\_\_\_\_\_ \* Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information. **I specifically authorize the release of information pertaining to psychiatric history, drug and/or alcohol abuse, HIV/AIDS and sexually transmitted diseases if such is a part of the medical record.**

I understand that the person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services unless authorization is required to bill my insurance company. The only circumstances when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon completion of criminal investigation and any pending criminal trial.

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Signature of Patient or Patient’s Legal Representative Date

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Print Patient’s Name or Name of Legal Representative (if applicable) Relationship to Patient

Revised 5/12