Cardiovascular Consultants

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Release of Medical Records

Patient Name: ____ **Date of Birth:** ___________________

Information to be released from: ____
Name of Designated Facility or Provider

____
Address

____ (_____)_______________
City, State, Zip Code Phone Number

MUST FILL OUT COMPLETELY

Information to be released to: ____
Name of Recipient

____
Address

____ (_____)_______________
City, State, Zip Code Phone Number

My Authorization:
You may disclose the following health care information (Check all that applies):
_____ All medical records. _____ Last two years ______Most recent.
_____ Specific information (Please specify) ____________________________________

Reason(s) for this authorization/disclosure (Check all that apply):
_____ Continuing Care _____ Insurance _____ Attorney _____ Personal
_____ Other (Please specify): ____

Reasonable Fee: Pursuant to RCW 70.02.010, a medical provider may charge a reasonable fee for producing copies of medical records. Insurance and Attorney requests will be billed in accordance to this RCW.
Patient Reasonable Fee: Pursuant to 45 CFR 164.524 (c) (4), HIPAA states that: "If the individual request a copy of the protected health information…the covered entity may impose a reasonable, cost-base fee." Which is as follows:
$23.00 Clerical Fee **1-30 pages**: $1.02 per page **Over 30 pages**: $.78 per page

Please check one: Leave at Clinic:________ Records to be mailed: ___________ (Postage will be added to the price.)

** Applicable sales tax will be charged.
Specific Disclosure: You may use or disclose health care information regarding testing, diagnosis and treatment for (Check all that apply and initial):
_____ Drug and / or alcohol abuse /treatment /diagnoses. _____ HIV (AIDS virus)
_____ STD (Sexually transmitted diseases). _____ Mental health or Psychiatric disorders.

My Rights:
I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in research study, or to receive healthcare when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by this facility based upon this authorization.
I may not be able to revoke this authorization if its purpose was to obtain insurance. The way to revoke this authorization is to write a letter to this facility. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

____ ___________________ __________
Patient or legally authorized individual signature Date Time

____ ______________________________
Printed name if signed on behalf of patient (personal rep) Relationship (Parent, Legal guardian)

This authorization will expire 90 days from date signed.