



Mid-Valley Medical Group

"personalized quality care"

PO Box 3188 - Omak, WA. 98841 - 509 826-1600 - fax 509 826-3633

a service of Mid-Valley Hospital

Patient Name: _____
last first Middle

Date of birth: _____

Address: _____

Phone: _____

City/State: _____

Social Security # _____

1. My Authorization

You may use or disclose the following health care information (check all that apply)

- All health care information in my record
- Health care information in my medical record relating to the following treatment or condition:

_____ Health care information in my medical records for the date(s): _____

_____ Other (e.g., x-rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol use

Please release records from:

Name: _____

Date records are needed by: _____

Address: _____

City/State/Zip: _____

Phone: _____

Provider reviewed for release: _____

Please forward copies of the above requested records to:

Name: _____

Address: _____

City/State/Zip: _____

Doctor: _____

Reason(s) for this authorization (check all that apply)

- Attorney
- Insurance
- Doctor
- Personal

2. 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 a research study or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Mid-Valley Medical Group based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain medical insurance.

To revoke this authorization, I must write a letter to medical records at Mid-Valley Medical Group.

To be valid this authorization must be dated within 90 days of the request for the information and can be revoked at any time, providing the information has not yet been released

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)