MedStop One
It's a family thing

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

All portions of this form must be completed to constitute a valid authorization for release of health information.

Patient's Name: _____ Date of Birth:_____ Telephone:_____

Address: _____

I request and authorize ***MedStop One*** to: (please check one)***(Please list any other facilities we could obtain records from)***

[] release information to [] obtain information from [] exchange information with

Name:_____

Address:_____

Phone:_____Fax:_____Email:_____

This request and authorization applies to:

[] Healthcare information relating to the following treatment, condition or date: _____

[] All Healthcare information

Purpose of Disclosure: _____

I understand that the above-mentioned named receiving agency/person/facility has a right to inspect and copy the information disclosed. I further understand that if the receiving agency/person/facility is not covered by Health Insurance Portability and Accountability Act (HIPPA) privacy regulations, the information described above may be re-disclosed and may no longer be protected by HIPPA regulations. I understand I may revoke the release of information at any time, in writing, except where the facility has already made disclosures in reliance upon my prior authorization. I understand the no revocation of this consent shall be effective to prevent disclosure of records and communications until it is received by Rural Health, Inc. It is my understanding that the records and communication to be disclosed may contain information about diagnoses/evaluation/rehabilitation/treatment/recommendation for mental health, developmental disabilities, and/or substance abuse/use and that my signature indicates my informed consent.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if HIPPA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

Definition: Sexually transmitted disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma, venereuem, HIV (Human Immunodeficiency Virus), AIDS (acquired Immunodeficiency Syndromes), and gonorrhea.

[] Yes [] No *I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.*
[]Yes [] No *I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.*

Patient's (or Guardian's) Signature: _____ Date: _____

Relationship to Patient/Authority to Act on Patient's Behalf_____

Witness Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED UNLESS REVOKED EARLIER

NOTICE TO WHOMEVER DISCLOSURE IS MADE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY STATE AND FEDERAL LAW. THESE LAWS PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHROIZATION FO RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.