AUTHORIZATION TO RELEASE PRIVATE INFORMATION

400 N. Main Street • Colfax, WA 99111 • (509) 397-5240 • FAX (509) 397-6355

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), I authorize the use/disclosure of my protected health information to the entity/person listed below and/or their authorized agent for purpose(s) listed below. I agree that by my signature below such information may be communicated under the Protected Health Information Rule* and may be used for audit or statistical purposes. I understand that my authorized representative or I will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.

I authorize the following people/organization to use/disclose my protected health information (please initial beside each person/organization): _____

_____

_____

_____

The following people/organization may receive my protected health information (please initial beside each person/organization): _____

_____

_____

_____

THIS REQUEST/AUTHORIZATION APPLIES TO:

Please describe in detail the information to be used or disclosed: _____

_____

_____

_____

Please describe in detail purposes for use/disclosure of each piece of protected health information (The statement "at the request of the individual" is a sufficient description of the purpose if you do not wish to elaborate. Please place a different date next to each use/disclosure necessary): _____

_____

_____

_____

Information will be sent via regular First Class Mail unless a space below is checked authorizing us to send via E-mail, over the phone and/or fax. Permission to send via E-mail, phone and/or fax is authorized. I understand the

information sent in this manner is not secure and agree to hold Whitman County, the receiving party and/or authorized representatives blameless for any misdirection that may occur exposing protected information.

Please send the above listed information via: _____E-mail _____Fax _____Phone

- I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment of HIV (AIDS) virus, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnoses, testing or treatment if related to the authorization above.

- I understand that this authorization can be revoked or rescinded upon written request to the disclosing party. However the revocation will not have any affect on any action the entity took before it received the revocation.

- I understand that I may see and copy this form, and the information described, if I ask for it.

- This is not a condition for health care benefits, and I am not required to sign this form to receive my health care benefits (treatment, payment, enrollment).

- Information used or disclosed to the authorized party is subject to re-disclosure and no longer protected by the Privacy Rule. You may seek assurances from the recipient to extend the protections of this authorization.

Unless otherwise revoked or rescinded in writing to the disclosing party, this authorization will remain in full force and effect until

_____, 20 _____.

_____ _____
Signature of Employee or Authorized Representative Date

_____ _____
Signature of Witness Date

_____
Relationship or status if signed by anyone other than employee (parent, legal guardian, etc.)

* Protected Health Information (PHI) is any individually identifiable information transmitted or maintained in any form or medium (electronic or otherwise). Identifiable information may include demographic, financial, medical/health, and/or social data.