



AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

Patient Information:

Name (Please print full name): _____ Date of Birth: _____
Email: _____ Phone#: _____
Address: _____

Release format:

Paper Copy Email (Secure) QR Code (Images Only) Electronic Hard Copy (CD-ROM)

Request information from listed provider: Astria Health System (to include Sunnyside and Toppenish Hospitals and all Astria Clinics)

Other: Name/Organization: _____
Phone: _____ Email: _____ Fax: _____
Address: _____

Send my information to: Name/Organization: _____

Phone: _____ Email: _____ Fax: _____
Address: _____

Purpose of Release: Health Care Personal Legal Billing Insurance

Other: _____

What information should be released: _____

Select type(s) of information that may be released:

Record Sets:

- Clinic Records (Includes: Office Visit, Laboratory, Radiology, Medication Record, Immunization Record)
- Hospital Records (Includes: H&P, Discharge Summary, Operative Report, Consultations, Emergency, Laboratory, Radiology)

Specific Documents Only:

- Discharge Summary/Note History and Physical Operative Report Radiology Report Radiology Images (QR Code)
- Lab Report Pathology Report Emergency Report Immunization Record Medication Record Clinic Note
- Rehab Note Other (Please Specify): _____

Specific Dates of Service: _____ OR **Most recent 2 years** (default if no dates listed)

Special Information: I authorize the inclusion of the following information with this release (**Initial all that apply**)

- _____ Sexually Transmitted Infections, including HIV/AIDS (RCW 70.02.220)
- _____ Psychiatric, Mental or Behavioral Health Information (RCW 70.02.230 or 240)
- _____ Substance Use Disorder (SUD) information (42 CFR Part 2)

****Note: If this section is not completed, records of this type (if they exist), will not be released****

Expiration:

This authorization is valid for 365 days from the date of signature or until the date/event specified here:

Signature:

Patient/Representative: _____ Date: _____

Legal Authority: _____ Date: _____
(Copy of identification that matches patient/representative is required for all record releases)

Minor Signature: _____ Date: _____
(Please sign if co-signature is required for minors – See page 2 under ‘Consent for Minors’ for clarification)

****If the authorization is signed by a personal representative of the individual, a description and written proof of such representative’s authority to act for the individual must also be provided.**

Printed Name & Date: _____ Relationship: _____

****Rights and other notices listed on Page 2****



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Your rights and other notices:

- Once Astria Health releases your health information, the recipient may re-disclose that information and privacy laws may no longer protect it. Some information, such as Substance Use Disorders or Mental Health may still be protected.
 - You can withdraw this authorization at any time (please refer to Revocation section below). If you withdraw your authorization, it will not change actions that were already taken according to that authorization.
 - Astria Health does not require you to complete this authorization to receive healthcare or healthcare benefits. However, you must sign this authorization form when the purpose of healthcare services or research participation is to create or receive health care information.
 - You understand this request for records may result in charges.
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Revocation:

You may revoke this authorization in writing. You may call the Health Information Management (HIM) department for more information and can obtain a copy of the form at: <https://www.astria.health/patients-visitors/medical-records/>. The revocation will be effective upon receipt, but will not apply to information that has already been released or to services already provided according to this authorization.

(RCW 70.02.040)

Consent For Minor:

A signature of a minor patient is required to release information concerning care for:

- Birth control and pregnancy related care
 - Sexually transmitted disease information to include HIV/AIDS if the minor is 14 or older
 - Substance use disorder diagnosis, treatment, or referral information for capable minors under 13, both minor and guardian must consent
 - Outpatient mental health information if the minor is 13 or older.
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Radiology Images:

- For a facility requesting images being pushed by PACS only, please contact the Radiology Dept. directly. Any written reports will be completed by the HIM Dept.
 - Radiology: 509-837-2760
 - For a patient requesting images, they will be provided in a QR Code form by CryptoChart™ from the HIM Dept. CryptoChart™ is a secure access link to share with physicians and patient without logins or passwords to manage, while being in full HIPAA compliance.
 - CDs of images can still be available upon request.
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This Authorization can be sent to us by Mail, Fax or Email:

Astria Health – Attn: Health Information Dept. 1016 Tacoma Ave, Sunnyside, WA 98944

Phone: 509-837-1636, Option 1 for Release of Information

Fax: 509-837-1637

Email: ROI@Astria.Health

Monday – Friday, 8:00am – 4:30pm, Closed all major Holidays
