SKYLINE HOSPITAL

Skyline Hospital - Consent for Release of Information

Patient Name (legible, legal name):	Maiden/nickname/other names:
Mailing Address:	Date of birth:
City, state, zip code:	Phone:

Please OBTAIN my information from:	**Please SEND my information to:**	
SKYLINE HOSPITAL P.O. BOX 99 WHITE SALMON WA 98672	Name of Person, Clinic or Hospital:	
	Address:	
	City, state, zip code:	
❑ Please call when records are ready for pick up.* ❑ Please mail records.* ❑ Please fax records.*	Fax To This Number:	Phone Number:

I authorize above named Hospital to release the following protected health information as noted above:

Specific treatment date(s) or admission(s) or date range: _____

Specific information as listed below:

❑ X-ray CD
❑ X-ray report
❑ Operative report
❑ Laboratory report
❑ History & Physical report
❑ Discharge summary
❑ Emergency report
❑ Progress note
❑ Other: _____

Purpose of this Release request: _____

I understand that certain information in these records cannot be released without specific authorization due to Federal and/or State law. **By initialing below**, I specifically authorize the release of the following confidential and protected health information:

_____ HIV test and/or other sexually transmitted disease test results and related information, including documentation of high-risk behavior.

_____ Drug and/or alcohol abuse, diagnosis, treatment.

_____ Genetic testing results and related information.

_____ Mental Illness/Psychiatric treatment information.

I give my specific authorization for these records to be released. My consent may be revoked at any time by written notification to Privacy Officer, Skyline Hospital, PO Box 99, White Salmon WA 98672. The only exception is when the action has already occurred as initially instructed in this Consent. Any care provided by Skyline Hospital will not be affected if you do not sign this form.

Patient signature:	Parent/Legal Guardian signature (if applicable):
Printed Name:	☐ Yes - Guardianship Paperwork on file. ☐ No - **Do not release** pending paperwork provided.
Date:	**Expiration Date of this Authorization/ROI:**
Please allow **15 days** for completion of your records request (RCW 70.02.080). There is **no charge** for records provided to patients or physicians, clinics and hospitals for **continuity of patient care**. **Skyline Hospital ROI Phone: 509-637-2943 | Fax: 509-493-4057**	
For official use only: Sent via: ❑ Mail ❑ Fax ❑ Picked up (by: _____) Legal ID checked: _____ ROI copy given: _____ Date records sent: _____ Release sent/processed by: _____	