TRI-CITIES PRECISION HEALTH
7015 W. Deschutes Ave, Ste A · Kennewick, WA 99336 · (509) 266-8274 · Fax (509) 331-5080 · tcph26@pm.me

Authorization for Release of Medical Records

HIPAA-compliant authorization — 45 CFR §164.508

1 · PATIENT INFORMATION

PATIENT FULL NAME _____ DATE OF BIRTH _____

PHONE _____ EMAIL _____

MAILING ADDRESS (STREET, CITY, STATE, ZIP) _____

2 · DIRECTION OF RELEASE (CHECK ONE)

☐ TCPH RELEASES my records TO another provider or party
☐ TCPH REQUESTS my records FROM another provider or party

3 · OTHER PROVIDER / PARTY (SEND TO OR REQUEST FROM)

NAME OF PROVIDER / FACILITY / PERSON _____

ADDRESS _____

PHONE _____ FAX _____

4 · INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY)

☐ Complete medical record
☐ Office/progress notes
☐ History & physical
☐ Laboratory results
☐ Imaging (X-ray, CT, MRI, ultrasound)
☐ Pathology reports
☐ Medication list / prescription history
☐ Immunization records
☐ Consultation reports
☐ Discharge summaries
☐ Billing records / superbills
☐ Other (specify below)

OTHER / SPECIFY: _____

DATE RANGE OF RECORDS
From: _____ To: _____ ☐ All available records

5 · SENSITIVE INFORMATION (SEPARATE AUTHORIZATION REQUIRED — CHECK TO INCLUDE)

☐ Mental health / behavioral health records
☐ Substance use / alcohol treatment (42 CFR Part 2)
☐ HIV/AIDS test results & treatment
☐ Genetic testing results
☐ Sexually transmitted infection records

6 · PURPOSE OF RELEASE

☐ Continuing care / referral
☐ Legal
☐ Personal use
☐ Insurance / disability claim
☐ Other: _____

7 · YOUR RIGHTS (PLEASE READ)

- You may refuse to sign this authorization. Your care, payment, enrollment, and eligibility for benefits will not be conditioned on signing, except where allowed by law.
- You may revoke this authorization at any time by giving written notice to Tri-Cities Precision Health. Revocation is not effective for information already released in reliance on this authorization.
- Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy law (HIPAA).
- You have a right to receive a copy of this signed authorization.
- This authorization is valid for one (1) year from the date of signing unless you specify a different expiration date or event below.

8 · EXPIRATION OF THIS AUTHORIZATION

☐ One (1) year from date signed (default if none selected)

☐ Specific date: _____

☐ Specific event: _____

9 · SIGNATURE

PATIENT SIGNATURE (OR PERSONAL REPRESENTATIVE) _____ DATE _____

PRINTED NAME _____ RELATIONSHIP (IF REP.) _____

IF SIGNED BY A PERSONAL REPRESENTATIVE, ATTACH DOCUMENTATION OF AUTHORITY (POA, GUARDIAN, PARENT)