SKYLINE HOSPITAL CONSENT FOR RELEASE OF INFORMATION	
Patient Name:	Maiden/Nickname/Other Names:
Address:	Date of Birth:
City/State/Zip:	Phone Number:

Please **OBTAIN** information **FROM**:	Please **SEND my information TO:** OR **Picked up by:**
Name of Physician:	Person to Receive my Information:
Name of Hospital/Clinic:	Title (Self, Spouse, Physician, Attorney, etc):
Address:	Address:
City/State/Zip:	City/State/Zip:

I authorize above named Hospital, Clinic or Physician to release the following protected health information:

____ Specific Treatment Date/s or Admission/s: ______________________________

____ Specific Information as Indicated Below:

- ☐ X-Ray Film/CD
- ☐ X-Ray Report
- ☐ Operative Report
- ☐ Laboratory Report
- ☐ History & Physical Report
- ☐ Discharge Summary
- ☐ ER Report
- ☐ Progress Note
- ☐ Other:

I understand that certain information in these records cannot be released without specific authorization because of Federal and/or State law. By **INITIALIZING** 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.
____ Genetic testing results and related information.
____ Drug and/or alcohol diagnosis, treatment and/or referral information.
____ Mental health treatment information.

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My consent may be revoked at any time. The only exception is when the action has already occurred as instructed in this Consent. **This Consent will expire one year from date of signature below.**

______________________________ Signature of Patient

______________________________ Signature of Parent or Legal Guardian (if applicable)

Date: ______________________________

______________________________ Signature of Witness

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For Office Use Only:

Date Records Sent: ______________________

Sent via (circle): Mail Fax Picked up

Picked up by: ______________________

Copy of Release Sent to: __________ on _______

***Fee Schedule/Payment Policy*:** Please note the fee for records on the back side of this form. Payment is expected prior to records being released to you. Once payment is received, your records will be sent within two business days. If you choose to pick up your records, payment can be made to a Patient Services Representative.
Release of Information Clerk: 509-637-2943
Medical Records Fax Number: 509-493-4057

RELEASE OF INFORMATION POLICY:

Skyline Hospital employees will release information as allowed by law.

* The Medical Records Department business hours are from 7:00 a.m. to 5:00 p.m., Monday through Friday.

* Please allow 24 hours notice before picking records up on site; However, emergency requests will gladly be honored.

* Release of Information (ROI) forms are scrutinized for validity. Requests shall be reviewed for the completeness of the authorization as follows:

  ~The form is filled out completely and legibly.

  ~There is a witness signature on the form.

  ~It is dated within one year.

  ~It has the correct signature of the patient or legal guardian (will be compared to signature/s on file in patient's chart). If we have no signature to compare or if someone else that you designate is picking up records, we will ask for ID when records are given to you/them. **Please Note: Only the patient or legal guardian may sign for release of records.**

* Fees for ROI requests will be charged in accordance with WA Administrative Code (WAC) 246-08-400. Fees will be evaluated / updated yearly when notification is received from WA State Department of Health.

* Fees for copying will be charged as follows:

  ~$20.00 (twenty dollar) clerical fee for searching, handling and providing/mailing records.

  ~For copying records less than two pages (i.e. one page) a clerical fee will not be charged.

  ~Any copying of records over ten pages will be charged $0.25 (twenty-five cents) per page. The first ten pages will not be charged a per-page fee.

  ~A fee of $1.00 will be charged for digital records copied onto a CD.

  ~No fees will be charged for sending records to physician's offices or hospitals for continuity of care.

  ~Payment for records must be obtained prior to records being mailed or picked up on site.

* As it is against WA State law to re-release records that do not belong to this facility, Skyline Hospital will not release records that do not originate at this facility.

* How to acquire Release of Information Form: Download ROI Form from our web site, pick one up at the hospital or have one mailed directly to you.

  Once you have filled out the Form:
  ~ Bring it to the hospital and leave it with the receptionist, who will route the Release Form to Kimberly Odle, Release of Information Clerk in Medical Records.
  ~ Fax the Form to the Medical Records Dept. at 509-493-4057.
  ~ Mail the Form to Kimberly Odle, Release of Information Clerk; Skyline Hospital; P.O. Box 99; White Salmon; WA; 98672.