

Longview Clinic
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Longview, WA 98632
360.578.2527 voice
360.575.1460 fax
www.hwnw.org



Chehalis Clinic
1522A Bishop Road
Chehalis, WA 98532
360.740.0444 voice
360.740.0704 fax
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CONSENT FOR RELEASE OF PATIENT RECORDS

I understand that my records are protected by Federal and State Confidentiality Laws and Regulations, and cannot be released without my written consent unless stated in those laws and regulations. Federal regulations also prohibit any person from making further disclosure without my specific written consent. I also understand that I may cancel this consent in writing at any time unless action has already been taken based upon it, and that in any event, this agreement expires 90 days from the date of signing. I understand that by initialing the boxes below, I agree to the release of records regarding as indicated below by initialing the appropriate boxes. I understand that my right to confidentiality does not protect any information about a crime committed, or suspected child abuse or neglect. In addition, if there is reason to suspect that I am in danger of physical or bodily harm, or that anyone else is in danger of physical or bodily harm, that information is not protected. It is with this understanding that I sign this form agreeing to the release of my records. This information has been disclosed to you from records protected by federal confidentiality rule (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the purpose. The Federal rules restrict any use of the information to CFR, Part 2. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This consent is subject to my revocation at any time except to the extent action has been taken in reliance thereof and unless earlier revoked, shall expire in 90 days from date of signature.

Please complete form with all information

Photo ID required before pickup records

Patient Information

Last _____ First _____ M.I. _____

Address _____

City _____ State _____ ZIP _____ Birthdate ____/____/____

Your Phone Number () _____ Social Security Number _____

Your EMPLOYER: _____

Patient Authorization

I authorize **HealthWorks Northwest** to receive/provide patient records from/to the following agency:

Agency Name: _____

Address: _____ Phone# _____

_____ Fax# _____

I authorize the release of the following patient records:

Alcohol/Drug
Treatment Records
 HIV/AIDS/BBP
Records

L&I Patient Visit -
Claim# _____
 Discharge Summary
 Progress Notes

History & Physical
 Pre-Employment testing
 Imaging Reports
 Other: _____

Patient Signature

Date