Byron L. Haney, MD
Family Practice

John R. Walters, MD
Family Practice

Chad A. Mongrain, DO
Family Practice

Stephanie Arar, MD
Family Practice

Rick D. Vaughan, MD
Family Practice

Michael Druschel, MD
Family Practice

Ryan J. Beachy, PA-C
Family Practice

Aaron D. Long, FNP-C, PA-C
Family Practice

Brent A. Meador
Business Manager

FAMILY HEALTH CARE
OF ELLENSBURG

Authorization for Release of Information

Patient Name:_____

Previous Last Name:_____ Phone Number:_____

DOB:_____

Release Information From:

Clinic/Dr: Family Health Care of Ellensburg
Address: 107 E. Mountain View. Ave., Ellensburg, WA. 98926
Phone: (509) 962-6348 Fax: (509) 962-2003

Send Information To:

Clinic/Dr:_____

Address:_____

_____

Phone:_____ Fax:_____

Information to Release:

- ☐ All records past 2 years
- ☐ All records
- ☐ Other, please specify: _____

Purpose of Disclosure (Circle One): Attorney Insurance Doctor Personal Transfer*

*Transfer = Upon date of signed release form I understand that I relinquish my status as an established patient at FHCOE. Future Re-establishment will be determined by the clinic regarding New Patient policies at that time. _____ (Patient Initials)

Fees: See Reverse Side

Patient Authorization: I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnoses, testing or treatment.

My Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party. I may revoke this authorization in writing. To view this process for revoking this authorization, please read the Privacy Notice to patients. I understand that once my health care information is disclosed, the person or organization that receives it may redisclose it, at which time it may no longer be protected under Privacy laws.

Signature:_____ Date:_____

Patient, Guardian, or Authorized Representative. Please provide documents to prove authority to sign on behalf of the patient. This authorization will expire 90 days from the date signed.

WAC 246-08-400

How much can a health care provider charge for searching and duplicating health care records?

RCW 70.02.010(37) allows health care providers to charge fees for searching and duplicating health care records. The fees a provider may charge cannot exceed the fees listed below:

(1) Copying charge per page:

(a) No more than one dollar and seventeen cents per page for the first thirty pages;

(b) No more than eighty-eight cents per page for all other pages.

(2) Additional charges:

(a) The provider can charge a twenty-six dollar clerical fee for searching and handling records;

(b) If the provider personally edits confidential information from the record, as required by statute, the provider can charge the usual fee for a basic office visit.

(3) HIPAA covered entities as defined in 45 C.F.R. Sec. 103 may not charge fees or costs that are not authorized by, or are prohibited by, Federal HIPAA regulation 45 C.F.R. Sec. 164.