AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PROVIDENCE
St. Mary
Medical Center

Diagnostic Imaging Library
401 W. Poplar St.
Walla Walla WA 99362-0312
(509) 522-5172
FAX (509) 522-5725

I, _____

herby authorize PSMMC to provide me or the following doctor/facility at this address:

_____

_____

_____

_____

Diagnostic images and/or reports for the exams:

_____

For the purpose of a self copy or continued care.

I understand that the information used or disclosed may be subject to re-disclosure by the recipient and is subject to re-disclosure and may no longer be protected under HIPAA (federal law). This authorization is valid for 90 days. I understand that I have a right to revoke my authorization at any time and that it must be in writing to be valid, except as documented in the Washington State Healthcare Information Act (section 203) and unless disclosure is required to obtain payment for care that has already been rendered. This revocation will become a permanent part of my record. I consent to transmitting via facsimile this information in an emergency situation.

Signature: _____ **Date:** _____
(patient/guardian/legal representative)

Your Birthdate: _____

For Facility Use

ID Used: _____

Witness: _____ Date: _____

Revised: February 2012