



55 WEST TIETAN
WALLA WALLA, WASHINGTON 99362
(509) 525-3720 • (800) 228-6053 • Fax: (509) 525-6897
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ Birth Date: _____
Address: _____ Telephone #: _____
E-Mail Address: _____ Former Name: _____

I hereby authorize:

(Individual/Agency)

(Address)

(City, State, Zip Code)

To provide medical information to:

(Individual/Agency)

(Address)

(City, State, Zip Code)

Data requested:

____ Physician notes _____ Operative Reports
____ Labs/Pathology Reports _____ History and Physical
____ X-Rays _____ EKG
____ Reports _____ All health care records
____ Films _____ Other: _____

For the purpose of: _____

Permission to fax and/or send electronically _____ YES _____ NO Fax #: _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, psychiatric treatment, or genetic information. I give my specific authorization for these records to be released.

***EXCLUDE the following information from the records released (please initial):**

____ Drug/Alcohol abuse/treatment & diagnosis _____ Sexually Transmitted Disease
____ HIV/AIDS diagnosis/treatment/testing _____ Sexually Transmitted Infections
____ Genetic Information _____ Mental Illness or Psychiatric diagnosis/treatment

This authorization will expire within 1 year. I may revoke this authorization in writing at any time, provided that the information has not yet been released. To view the process for revoking this authorization, please read the Privacy Notice to our patients. I understand that once the Walla Walla Clinic discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under Privacy laws. I understand I do not have to sign this authorization in order to receive health care benefits.

Patient Signature Date/Time Parent, Legal Guardian or Authorized Representative* Date/Time
[*Please provide documents to prove authority to sign on behalf of the patient]

Walla Walla Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Walla Walla Clinic does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Walla Walla Clinic:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services please contact our clinic Interpreter, or Administration, at 509-525-3720.

If you believe that Walla Walla Clinic has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you have the right to file a grievance with:

Walla Walla Clinic Administration,
55 W Tietan St., Walla Walla, WA 99362,
509-525-3720, Fax 509-522-1593

You may file a grievance in person, phone, mail or fax. If you need assistance filing a grievance please contact our clinic Interpreter, or Administration at the number above.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F,
HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-525-3720 extensión 1221.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-509-525-3720, 1221。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-509-525-3720, 1221.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-509-525-3720, 1221 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-509-525-3720, 1221.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-509-525-3720, 1221

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-509-525-3720, 1221.

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-509-525-3720, 1221

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-509-525-3720, 1221 まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶቻችን በአ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-509-525-3720, 1221.

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-509-525-3720, 1221.

509-525-3720- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1 1221

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-509-525-3720, 1221 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-509-525-3720, 1221

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 1-509-525-3720, 1221.