COLUMBIA MEMORIAL HOSPITAL

2111 Exchange Street
Astoria, Oregon 97103
Tel: 503-338-7528
Fax: 503-325-6841

RELEASE OF INFORMATION

Purpose: This form is an authorization to release protected health information.

SECTION A: Patient Information

Name: _____

Address: _____

Telephone: _____ Date of Birth: _____

SECTION B:
Protected Health Information to be Released

Date of Service OR Description of Service

- ☐ Emergency Room _____
- ☐ Lab Reports _____
- ☐ Imaging CD/ Reports _____
- ☐ EKG/ EEG _____
- ☐ History & Physical _____
- ☐ Inpatient Progress Notes _____
- ☐ Operative Report _____
- ☐ Discharge Summary _____
- ☐ Clinic Chart Notes _____
- ☐ Physical Therapy _____
- ☐ Other* _____

(**specify*) _____

SECTION C:

☐ **Send Records To:** ☐ **Request Records From:**

_____
Individual/Facility / Agency

_____
Address

_____
City / State / Zip

_____
Tel Number

_____
Fax Number

_____
Email Address

SECTION D: I specifically release the following:

- ☐ HIV/AIDS/STD's_____ (Initials)
- ☐ Mental Health Diagnosis and Treatment_____ (Initials)
- ☐ Drug/Alcohol Diagnosis and Treatment_____ (Initials)
- ☐ Genetic Info_____ (Initials)

PATIENT'S SIGNATURE.

I have had the full opportunity to read and consider the contents of this authorization. I understand that by signing this form I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Patient Signature/Representative: _____Date: _____

Personal Representative's Name:_____

Relationship to Patient:_____

SECTION E: Purpose of this Authorization:

☐ Continuing Care ☐ Insurance ☐ Legal ☐ Other:_____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

PATIENT STICKER

H I P P 1

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HIPAA Form 3B
Revised 08-15-17

Include this authorization in the individual's medical records

FOR HOSPITAL USE

Date prepared: _____ Initial: _____

Date of release: _____ ☐ Pt. Pick-Up ☐ Mailed ☐ Faxed ☐ Electronic

Verification of ID: ☐ Photo ID ☐ Person is known to me ☐ Government Credentials

Verified by: *(CMH Staff Signature):* _____

Medical Record Number_____

PATIENT STICKER