Inter Island Medical Center

550 Spring Street (360) 378 – 2141 Phone
Friday Harbor, WA 98250 (360) 378 – 3655 Fax

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT INFORMATION:

LAST NAME: ________________________________ FIRST NAME: __________________ MI: ________

SOCIAL SECURITY#:____________________________ DATE OF BIRTH: _________________________

FORMER NAME(S):_______________________________ DAYTIME PHONE: ______________________

INFORMATION TO BE RELEASED **FROM**:

NAME OF FACILITY: ____

ADDRESS/PHONE/FAX #: ____

INFORMATION TO BE RELEASED **TO**:(if released for personal records, you must initial the disclosure on back)

NAME OF FACILITY: ____

ADDRESS/PHONE/FAX #: ____

TYPE OF INFORMATION TO BE RELEASED:

☐ Medical Records Date(s) of service: From____________________ To____________________
Limited to 2 years of information unless otherwise specified.

☐ Lab Results Date(s) of service: From____________________ To____________________
Tests must have been ordered and reviewed by an IIMC Physician prior to release.

☐ X-ray (report only) Body part: ______________________________ Date: ________________
**Films must be requested from Island Hospital Diagnostic Imaging 1-360-299-1315*

REASON FOR THIS REQUEST:____

I AUTHORIZE RELEASE OF MY MEDICAL RECORDS, to include records specified below if initialed:

____ ________________ ________________
➢SIGNATURE OF PATIENT/GUARDIAN RELATIONSHIP DATE

I specifically authorize release of healthcare information related to testing, diagnosis, or treatment of: (initial)

_____ HIV / AIDS _____Mental Health/Psychiatric disorders
_____Drug / Alcohol Abuse &/or Treatment _____Sexually Transmitted Diseases

NOTE: By State Law, minors must give their written consent before records can be released that relate to any of the above topics, as well as records related to pregnancy and contraception.

____ ________________ ________________
➢SIGNATURE OF MINOR PATIENT (if required) RELATIONSHIP DATE

Please read the disclosures on the second page of this form.

- ➢This Authorization for Release will expire in 90 days.

- ➢Release of medical data may include re-disclosure of medical information obtained from other providers in accordance with your wishes.

- ➢You do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). You do have to sign an authorization form to receive health care when the purpose is to create health care information for a third party, or to take part in a research study.

- ➢You may revoke this authorization in writing. This would not affect any actions already taken by Inter Island Medical Center based upon this authorization. You may not be able to revoke this authorization if its purpose was to obtain insurance.

- ➢In accordance with the Washington Uniform Health are Information Act, the policy of IIMC is to charge a reasonable fee for releasing medical records to individuals. Conforming to the fee schedule approved by the District Commissioners, the fees are as follows:

Clerical fee:	$15.00
Copy fee:	$0.50 per page

If the records you request are greater than 30 pages, we will save them to a CD unless otherwise requested. The fees for this service are as follows:

Clerical fee:	$15.00
Flat fee:	$15.00

I understand that I will be charged for release of my medical records for personal use. __________
(initials)