Reliance Health Systems

1446 Spaulding Ave, Richland, WA 99352
Phone: 509-420-5060 | Fax: 509-420-5059
https://rhs.health

Release of Information

Patient Name: ____ **Date of Birth:** ______________

1. I authorize Reliance Health Systems to (select one only):

- ❏ Release my records to the Medical Institution/Provider below (proceed to section 2)
- ❏ Receive my records from the Medical Institution/Provider below (proceed to section 2)
- ❏ Maintain verbal and written communication with the Medical Institution/Provider below (proceed to section 2)

2. Medical Institution/Provider: ____

Address: _________________________________ City: ____________ State: ______ Zip Code: _______

Telephone: __________________________________ Fax: __________________________________

3. For the purpose of: ❏ Continuing Care ❏ Personal Records ❏ Insurance Review ❏ Legal Review
❏ Other: ____

4. Consisting of: Dates of Service: ____

❏ Outpatient Psychiatric Notes	❏ Inpatient Psychiatric Notes
❏ Mental Health Therapy Notes	❏ Child Welfare/CPS Reports
❏ Medical Progress Notes	❏ Developmental Evaluation
❏ Laboratory/Test Results	❏ Education Records/ Plan
❏ Emergency Department Notes	❏ Chemical Dependency Records

❏ Other: ____

5. If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. **I understand and agree that this information will be disclosed only if I place *initials* in the applicable space next to the type of information.**

_____ HIV/AIDS testing/treatment and Genetic Testing

_____ Mental Health Information or Drug/Alcohol Diagnosis, Treatment, and/or Referral Information

*You are not obligated to sign this authorization. Refusal to sign will not adversely affect your ability to receive healthcare services **unless** the disclosure is needed to supply information for a higher level of care. You may retract this authorization at any time. By revoking this authorization, the information described above will no longer be used to disclose your health information for the purposes specified in this form. To revoke this authorization, please bring in or mail a written statement addressed to the "Reliance Health Systems, Medical Records Department, 1446 Spaulding Ave Ste 303, Richland WA 99352" stating that you are revoking this authorization.*

6. By signing this form, I authorize and consent to the release of my medical records. Unless I revoke this authorization, it will remain valid for 90 days from the date it was signed.

Patient Signature: ____ **Date:** ______________

Printed Name: ____ **Relationship to Patient:** __________