

Columbia Valley Community Health  
Authorization to Use and Release Information

Chelan  
PO Box 2920  
Chelan, WA 98816  
Ph. (509) 682-6000  
Fax (509) 682-6296

Behavioral Health  
504 Orondo Ave., Ste. A  
Wenatchee, WA 98801  
Ph. (509) 662-4296  
Fax (509) 664-1037

Wenatchee  
600 Orondo Ave., Ste. 1  
Wenatchee, WA. 98801  
Ph. (509) 662-6000  
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1(800) 288-7649

**RELEASE FROM:**

|                               |       |     |
|-------------------------------|-------|-----|
| Agency/Name                   | ( )   | ( ) |
|                               | Phone | Fax |
| Address, City, State, and Zip |       |     |

**SEND TO:**

|                               |       |     |
|-------------------------------|-------|-----|
| Agency/Name                   | ( )   | ( ) |
|                               | Phone | Fax |
| Address, City, State, and Zip |       |     |

**Purpose of Disclosure:**

Attorney     Insurance     Provider     Personal     Exchange information with: \_\_\_\_\_

**Information to be released:** (please check one)

The most recent pertinent information (Last several Doctor/Clinician notes, Plan of Care, Risk Management, Medical Flow Sheet, Face to Face, Medical History Sheet and Labs)

Specific Information (please specify): \_\_\_\_\_

**Client Rights:** I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization at any time. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.


**Client Authorization:** 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, or psychiatric treatment*. I give my specific authorization for this information to be released: Yes\_\_\_\_ No\_\_\_\_

**This Authorization is valid for:** (Check one box or request is invalid)  
 1 day     90 days     180 days     Indefinite

Print Client's full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

|                                 |             |
|---------------------------------|-------------|
| Signature: _____                | Date: _____ |
| Witness: _____                  | Date: _____ |
| Patient Representative: _____   | Date: _____ |
| Signature of Interpreter: _____ | Date: _____ |



**Office Use Only**

Please Check Appropriate Box:     File In Chart Or Cabinet     Process - Send Records     Fax