Mason Health
Mason General Hospital • Mason Clinic

AUTHORIZATION FOR RELEASE OF INFORMATION

Mason Health | Shelton, WA 98584

Patient Information	**Name:**		**DOB:**
	Address:		
	City:	**State:**	**Zip:**
	Home Phone:	**And/or Cell Phone:**	
Clinic/Hospital/Healthcare Provider: ***WHO*** **HAS THE INFORMATION YOU WANT RELEASED? PLEASE LIST SPECIFIC HOSPITAL AND/OR CLINIC:**	**Name:**		
	Address:		
	City:	**State:**	**Zip:**
	Phone:	**Fax Phone:**	
SEND TO: ***WHERE*** do you want the information sent? ***WHO*** may have the information?	**Name:**		
	Address:		
	City:	**State:**	**Zip:**
	Phone:	**Fax Phone:**	

DELIVERY METHOD FOR REQUEST:

☐ MAIL ☐ FAX (no more than 25 pages) ☐ PICK UP

PICK UP DATE: _____

PICK UP LOCATION: _____

Information to be Released:

WHAT **do you want sent or released?**

CHECK THE APPROPRIATE BOX!

Any and all records (includes ALL types of records listed below)

- ☐ Recent **2 years** of physician reports, labs, x-rays, & special tests
- ☐ **Clinic** (office visit, lab, radiology, medicines, immunizations)
- ☐ **Hospital** (history, discharge summary, consultations, emergency, lab, radiology, operative reports)
- ☐ Billing Record ☐ Films/Images ☐ Labs ☐ Radiology/Diagnostic studies
- ☐ Specific information (Specify): _____

Indicate date(s) of service _____

PLEASE CHECK IF YOU WANT THIS INFORMATION SENT

PLEASE SIGN HERE

Specific Authorization: I understand that my records may contain information regarding the testing, diagnosis and/or treatment of the following:

☐ Drug and/or Alcohol Abuse ☐ Mental Illness ☐ HIV/AIDS

☐ Sexually Transmitted Diseases ☐ Psychiatric Treatment

SIGNATURE: _____ **Initial if you decline:** _____

PURPOSE OF RELEASE (*WHY* IS IT NEEDED?)

☐ Transfer of care ☐ Personal use/review ☐ Legal ☐ Insurance Application

☐ Other _____

I give my specific authorization for these records to be released. ***IF PATIENT HAS REACHED HIS/HER THIRTEENTH (**13**) BIRTHDAY, **ONLY THE PATIENT CAN AUTHORIZE DISCLOSURE RELATING TO THE ABOVE SPECIFIED CONDITIONS.**

My Rights: I understand I have a right to request and receive a Notice of Privacy Practices. I may inspect and receive a copy (a nominal fee may be charged). Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing the authorization. I may revoke this authorization in writing by presenting it as provided in the Notice of Privacy Practices for the Facility, but the revocation will not apply to information already used or disclosed. I understand that once the health information I 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. The provider must make the healthcare information available within 15 working days after receiving the request or notify the patient of any delay. (RCW70.02.080)

SIGNATURE: _____ Relation (if not self): _____ Date: _____

*****THIS AUTHORIZATION EXPIRES ONE YEAR FROM DATE SIGNED ABOVE*****

☐ ID Checked (Driver's License, Military ID, Photo ID, SS Card) Reception Initials: _____ Pick Up Date: _____

[PATIENT LABEL]

STAFF initials: _____

ROI COMPLETION DATE: _____

*****SEE BACK OF FORM FOR SPECIFIC LOCATION*****

Mason Health
Mason General Hospital • Mason Clinic

AUTHORIZATION FOR RELEASE OF INFORMATION

Mason Health | Shelton, WA 98584

Mason General Hospital

P.O. Box 1668
901 Mountain View Dr. Shelton, WA 98584
Phone: 360-427-9587
Fax: 360-427-9592

Mason Clinic Hoodsport Primary Care

P.O. Box 1668
Shelton, WA 98584
Phone: 360-432-7781
Fax: 360-877-0565

Mason Clinic

P.O. Box 1668
Shelton, WA 98584
Phone: 360-426-2653 / 800-824-8885
Fax: 888-985-0681

Eye Care - MS 2

General Surgery - MS 2

Orthopedics - MS 4

Pediatrics - MS 3

Primary Care - MS 1

Podiatry - MS 2

Walk-In - MS 4

Women's Health - MS 3