

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Completion of this request can take up to 15 business days from date of receipt.

Patient Name: _____ Previous Name(s): _____

Phone number: _____ Date of Birth: _____ Social Security #: _____

Information to be released:

- ☐ All health care records in last 3 years and pertinent chart information (i.e. Immunization Record, Growth Charts, Op Notes)
☐ All health care records in last _____ years and pertinent chart information
☐ All health care information related to the following treatment/condition: _____
☐ Vaccines/Immunizations

The following protected areas of healthcare records require specific authorization and *will be excluded* from the information released unless specifically authorized below. **I request that the following information be included in this medical release (please initial each line you wish to be included);**

_____ HIV/AIDS _____ Sexually transmitted diseases _____ Psychiatric disorders/mental health _____ Drug and/or alcohol use

Purpose for release (initial one): _____ Coordination /Transfer of Healthcare _____ Payment/Insurance Claims
_____ Personal Use/Patient Request _____ Life Insurance/disability Insurance _____ Attorney/Legal Request
_____ Employment _____ Academics _____ Other: _____

Information to be released **FROM:** ****if any section below is left blank this release will be denied***

Name/Title/Organization: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Information to be released TO: ****if any section below is left blank this release will be denied****

Palouse Medical Palouse Health Center Palouse Pediatrics Family Medicine Residency Center Pullman Family Medicine

Name/Title/Organization: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

My Rights:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. If I did, it would not affect my actions already taken by Pullman Family Medicine, based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once health care information is disclosed, the person organization that receives it may re-disclose it. Privacy laws may no longer protect it.

This release shall expire on: **(PLEASE INITIAL ONE ONLY)**

_____ Specific date: ____/____/____ _____ Specific event: _____
_____ 90 days from today _____ 1 year from today

Patient or legally authorized individual signature

Date

Time

Printed Name

Relationship to patient