PULLMAN REGIONAL PRIMARY CARE
PULLMAN REGIONAL HOSPITAL

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 (e.g., immunizations, growth charts, op notes)
- ☐ All health care records in las____ years and pertinent chart information
- ☐ All health care information related to this treatment/condition: _____
- ☐ Vaccines / Immunizations

PROTECTED INFORMATION (initial each category you want included)

____ HIV/AIDS ____ Sexually transmitted diseases ____ Psychiatric disorders / mental health

____ Drug and/or alcohol use

PURPOSE FOR RELEASE (initial one)

____ Coordination / Transfer of Healthcare
____ Personal Use / Patient Request
____ Employment
____ Attorney / Legal Request
____ Payment / Insurance Claims
____ Life Insurance / Disability Insurance
____ 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

Select one clinic.

- ☐ 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 do, it will not affect actions already taken by Pullman Regional based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once health information is disclosed, the person or organization receiving it may re-disclose it. Privacy laws may no longer protect it.

THIS RELEASE SHALL EXPIRE ON (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