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

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