CLINIC NETWORK
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 (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: Palouse Health Center
Address: 305 E. Main St., Suite 102 City Palouse State: WA Zip: 99161
Phone: (509) 878-1890 Fax (509) 715-2125

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