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**AUTHORIZATION TO DISCLOSE MY HEALTH CARE INFORMATION**

Patient Name \_\_\_\_\_ Previous Name \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Information to be released:

- All health care records in last 6 years
- All health care information related to the following treatment/condition:

Other: \_\_\_\_\_  
 \_\_\_\_\_

**\*INCLUDE** the following information from the records released (please initial):

\_\_\_\_\_ HIV (AIDS virus)      \_\_\_\_\_ Sexually transmitted diseases  
 \_\_\_\_\_ Psychiatric disorders/mental health      \_\_\_\_\_ Drug and/or alcohol use

Information to be released **FROM:** \_\_\_\_\_  
 Name (or title) and organization

Address      City State      Zip  
 Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Information to be released **TO:** \_\_\_\_\_  
 Name (or title) and organization

Address      City State      Zip

**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 any actions already taken by Pullman Family Medicine, PLLC 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 or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

\_\_\_\_\_  
 Patient or legally authorized individual signature      Date      Time

\_\_\_\_\_  
 Printed name if signed on behalf of patient      Relationship to patient

**915 NE Valley Rd □ Pullman, WA 99163 □ Phone (509) 332-3548 □ Fax (509)789-9011**  
*This Authorization expires 90 days after the date is signed unless otherwise noted*