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AUTHORIZATION TO USE OR DISCLOSE MY HEALTH CARE INFORMATION

Patient Name: Previous Name(s): PFM Acct #:
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:

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 virus) Sexually transmitted diseases
Psychiatric disorders/mental health Drug and/or alcohol use

Purpose of release (at least one box MUST be checked):

- Coordination of Healthcare/Transfer of Care
Personal Use/Patient Request
Employment
Academics
Payment/Insurance Claims
Life Insurance/Disability Insurance
Attorney/Legal Request
Other:

Information to be released FROM:

Pullman Family Medicine, PLLC
915 NE Valley Road
Pullman, WA 99163
Phone: 509-332-3548
Fax: 509-332-5253
Email: feedback@pullmanfamilymed.com

Information to be released TO:

Name/Title/Organization:
Address: State: Zip:
Phone: Fax: Attn To:

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.

This release shall expire on (date) / / or upon the following event (whichever is sooner):

Patient or legally authorized individual signature

Date Time

Printed Name

Relationship to patient