



Permission to Access Medical Records

I, _____, allow _____
(Printed name of Patient) (Full name & relationship to patient)

to access my medical records beginning _____, 20 __ __ until _____, 20 __ __.
(Month/Day/Year) (Month/Day/Year)

If I choose to end this consent before the expired date, I must contact Pullman Family Medicine and another form must be completed.

This access includes (please initial):

- ___ Appointment information
- ___ Billing & Payment Information
- ___ Health information from other providers
- ___ Diagnoses
- ___ Treatment
- ___ Symptoms
- ___ Test Results

Under Washington Law, the following areas of the medical record require specific authorized consent. Please initial below to authorize access to these protected areas of your medical record if you wish for them to be included in this authorization.

- ___ Mental Health/Psychiatric Disorders/Depression/Anxiety
- ___ Sexually Transmitted Disease (STD): Testing, Results, Treatment, or Symptoms
- ___ HIV/AIDS virus: Testing, Results, Treatment, or Symptoms
- ___ Substance Abuse/Use, Drug and/or Alcohol Abuse/Use

Printed name of patient

____/____/____
Date of Birth

Patient Signature

Date **Time**

Office Staff Witness

Date **Time**