Palouse Heart Center
Palouse Pediatrics
Palouse Psychiatry & Behavioral Health
Palouse Pulmonology & SleepMedicine
Pullman Family Medicine
Palouse Health Center

Authorization to Use or Disclose Protected Health Information

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. Labs, immunization record, growth charts, operative notes, etc.)
____ 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
____ Psychiatric disorders/mental health
____ Psychotherapy notes
____ Sexually transmitted diseases
____ Drug and/or alcohol use

Purpose for release (at least one box **MUST** be initialed):

____ 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**: ****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: _____

Completion of this request can take up to 15 business days from date of receipt.

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 Regional Hospital Clinic Network, 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: ____/____/____
____ 90 days from today
____ Specific event: _____
____ 1 year from today

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed by an individual other that the patient Date Time