



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

Permission to Access Medical Records

Patient Name: _____ Date of Birth: _____

By my signature on this form, I authorize access for the following individual(s) to the following areas of my medical records until _____.
 (Month/Day/Year)

If I choose to end this consent before the expiration date, I understand that I must contact the respective clinic of Pullman Regional Hospital Clinic Network to make any edits to access or to revoke consent entirely.

Name	Phone Number	Relationship
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Please initial each area this access includes:

_____ Appointment Information (Initial)	_____ Treatment (Initial)
_____ Billing & Payment Information (Initial)	_____ Symptoms (Initial)
_____ Health Information from other providers (Initial)	_____ Test Results (Initial)
_____ Diagnosis (Initial)	

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 (Initial)
_____ Sexually Transmitted Infections (STI): Testing, Results, Treatment, or Symptoms (Initial)
_____ HIV/AIDS Virus: Testing, Results, Treatment, or Symptoms (Initial)
_____ Substance Abuse/Use, Drug and/or Alcohol Abuse/Use (Initial)

I acknowledge I have read and understand the contents of this document and that my signature is made voluntarily, of my own free will.

 Printed name of patient

 Date of Birth

 Patient Signature

 Date

 Time