AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name:_____ Date of Birth_____

Other names records may be under_____

I authorize release of records

FROM:

Tolt River Family Medicine
PO Box 1184
Carnation, WA 98014
Phone 425-333-4600
Fax 425-333-4646
ToltFamily.com

TO:

Practitioner:_____

Facility:_____

Address:_____

_____

Phone:_____

Fax:_____

Information to be released:

- ❑ Continuity of care report
- ❑ Last office visit note
- ❑ Last PAP/HPV report
- ❑ Last 2 years of blood work and imaging reports
- ❑ Immunization record
- ❑ Growth chart
- ❑ Other: _____

EXCLUDE diagnosis, testing, and treatment information related to the following from the records released if initialed below:

_____HIV/AIDS
_____Sexually transmitted diseases
_____Psychiatric disorders/ mental health
_____Drug and/or alcohol use

I understand that my express consent is required to release any health care information relating to testing diagnosis and/or treatment for HIV/AIDS, sexually transmitted diseases (STD), psychiatric disorders, or drug/alcohol use. If I have been tested, diagnosed, or treated for HIV/AIDS, STD's, psychiatric disorders or drug/alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment unless an exclusion is indicated above by my initials.

I understand I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party. Revocation of this authorization must be made in writing. I understand that once a practitioner discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under privacy laws.

This authorization expires 90 days after the date it is signed. Copying fee and prepayment may be required.

Patient Signature:_____ Date: _____
Parent/Guardian Signature_____ Date: _____

Office Use Only

Sent Via_____

Initials_____

Date:_____