Apple A Day Family Medicine

Authorization to Use or Disclose My Health Information

Patient Name:_____ Previous Name(s):_____

Date of Birth:___/___/___ Social Security #:_____ Phone number:_____

Information to be released: (please check one box)

- All health records in the last 3 years and pertinent chart information (i.e. immunization record,growth charts, Op notes, etc.)
- 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 infections

_____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
- Other:_____

Information to be released **FROM**:

Name/Title/Organization_____

Address:_____**City:**_____ **State:**____ **Zip**_____

Phone:_____ **Fax:**_____ **Attn: Records Department**

Information to be released **TO**:

Apple A Day Family Medicine
1205 SE Professional Mall Blvd, Suite 105
Pullman WA, 99163
(509)332-2400 – Phone
(509)332-2402- Fax

Please Mail Records To
Apple A Day Family Medicine
PO Box 996
Pullman, WA 99163

My Right:
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 Apple A Day Family Medicine based upon this authorization.

This release shall expire on (date) _____/_____/_____

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed Name Relationship to Patient