Authorization for Release of Information

Fisher's Landing Primary Care

406 SE 131st Ave Vancouver WA 98683

(P) 360-816-0277 (F) 360-567-4004

Print Name:_____ DOB:_____

Email Address:_____ Phone:_____

INFORMATION TO BE RELEASED TO:

DR / CLINIC / SELF/OTHER _____

PHONE NUMBER_____ FAX NUMBER_____

INFORMATION TO BE RELEASED FROM:

FISHERS LANDING PRIMARY CARE
406 SE 131ST AVE STE C 305
VANCOUVER WA 98683
PHONE- 360-816-0277
FAX- 360-567-4004

___ The most recent *2 years* of pertinent information
(Op reports, chart notes, labs, x-rays, immunizations& specific tests)

___ Specific information to be sent _____

___ Other_____

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted infections, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

☐ I am the parent/guardian of this patient

SIGNATURE: _____ **DATE:**_____