

Authorization for Release of Information Fisher's Landing Primary Care

406 SE 131 Ave Ste 305 Vancouver WA 98683

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

Print Name: _____ DOB: _____

Email Address: _____ Phone: _____

INFORMATION TO BE RELEASED FROM:

Dr/Clinic/Self/Other:

Phone Number: _____ Fax number: _____

INFORMATION TO BE RELEASED TO: FISHERS LANDING PRIMARY CARE
406 SE 31ST AVE Ste C305
Vancouver WA 98683
P:360-816-0277 F: 360-567-4004

PLEASE SPECIFY INFORMATION TO BE SENT:

_____ The most recent 2 years of pertinent information: (Op reports, chart notes, labs, x-rays immunization's & specific tests).

Specific Information to be sent: _____

_____ Other _____

PATIENT AUTHORIZATION:

I understand that my records 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 the patient.

SIGNATURE: _____ DATE: _____