walla walla clinic
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ Birth Date: _____

Address: _____ Telephone #: _____

E-Mail Address: _____ Former Name: _____

I hereby authorize:

_____
(Individual/Agency)

_____
(Address)

_____
(City, State, Zip Code)

To provide medical information to:

_____
(Individual/Facility)

_____
(Address)

_____
(City, State, Zip Code)

Date(s) of treatment: _____

Data requested: _____

_____ Physician notes	_____ Operative Reports
_____ Labs/Pathology Reports	_____ History and Physical
_____ X-Rays	_____ EKG
_____Reports	_____All health care records
_____Films	_____Other: _____

For the purpose of: _____

Permission to fax and/or send electronically _____YES _____NO Fax #: _____

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

***EXCLUDE the following information from the records released (please initial):**

_____ Drug/Alcohol abuse/treatment & diagnosis	_____ Sexually Transmitted Disease
_____ HIV/AIDS diagnosis/treatment/testing	_____ Mental Illness or Psychiatric diagnosis/treatment
_____ Genetic Information	

This authorization will expire within 1 year. I may revoke this authorization in writing at any time, provided that the information has not yet been released. To view the process for revoking this authorization, please read the Privacy Notice to our patients. I understand that once the Walla Walla Clinic 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. I understand I do not have to sign this authorization in order to receive health care benefits.

Patient Signature Date/Time Parent, Legal Guardian or Authorized Representative* Date/Time

[*Please provide documents to prove authority to sign on behalf of the patient]