



walla walla clinic

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ MR #: _____

Address: _____ Telephone #: _____

Previous Name(s): _____ Birth Date: _____

Date Requested By: _____ Upcoming Appointment _____ YES _____ NO

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

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]