

## Authorization to Disclose My Health Care Information To:

Palouse Medical, P.S.  
825 SE Bishop BLVD Suite 200  
Pullman, WA 99163  
Phone: (509) 332-2517  
Fax: (509) 334-9247

Palouse Medical, P.S.  
719 S. Main  
Moscow, ID 83843  
Phone: (208) 882-3510  
Fax: (208) 882-5143

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Previous name: \_\_\_\_\_

### I. My Authorization

You may disclose the following health care information (check all that apply):

- All health care information in my medical record  
 Health care information in my medical record relating to the following treatment or condition:  
\_\_\_\_\_  
 Health care information in my medical record for the date(s): \_\_\_\_\_  
 Other (e.g., X rays, bills), specify date(s): \_\_\_\_\_

**DO NOT disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):**

- HIV (AIDS virus)  Psychiatric disorders/mental health  
 Sexually transmitted diseases  Drug and/or alcohol use

I'm requesting my personal health care information from:

Facility /Physician Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**This authorization ends: one year from date signed or as specified below**

**X** \_\_\_\_\_

### II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
  - To receive health care when the purpose is to create health care information for a third party.
- I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Facility/Physician based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
- Fill out a revocation form. Or
  - Write a letter to the Facility/Physician you requested your records from.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed name if signed on behalf of the patient  
Last updated 3/06

\_\_\_\_\_  
Relationship  
(parent, legal guardian, personal representative)