

**Authorization for Palouse Medical, P.S.
to Disclose My Health Care Information to:**

Name or Organization: _____

Address: _____ City: _____ State: _____ Zip: _____

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): _____

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

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

I'm requesting my personal health care information from: Palouse Medical, P.S.

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

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

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)