Palouse Medical, P.S.
509.332.2517
Fax (509.334.9247)

825 SE Bishop Blvd., Suite 200 Pullman, WA 99163
www.palousemedical.com

Pullman ReadyCare
509.332.8847

AUTHORIZATION TO REQUEST/DISCLOSE PROTECTED HEALTH INFORMATION

Patient name: ____ Date of birth: ________________

Previous name: ____

☐ **May REQUEST Protected Information From:** ____

☐ **May DISCLOSE Protected Health Information To:** ____

Address: ____ City: _______________ State: ____ Zip: _________

MY AUTHORIZATION APPLIES TO ALL THE FOLLOWING HEALTH CARE INFORMATION *(Please 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)*: ____

DISCLOSURES REQUIRING SPECIFIC AUTHORIZATION *(Please check all that apply)*

You may disclose health care information regarding testing, diagnosis, and treatment for:

☐ HIV/AIDS
☐ Mental Health or Illness
☐ Reproductive Care *(minors only)*
☐ Sexually Transmitted Diseases
☐ Drug and/or Alcohol Abuse
☐ Electronic Format

***PLEASE NOTE:** A minor patient's signature is REQUIRED in order to disclose information related to reproductive care, sexually transmitted diseases *(if age 14 and older)*, HIV/AIDS *(if age 14 and older)*, drug and/or alcohol abuse *(if age 13 and older)*, and mental health or illness *(if age 13 and older)*.

REASON(S) FOR THIS AUTHORIZATION TO DISCLOSE MY HEALTH CARE INFORMATION: *(Please check all that apply)*

☐ At My Request ☐ Other (Specify) __________________________ ☐ For Marketing Purposes

Palouse Medical/Pullman Readycare does not participate in personal health information fund raising nor provide health care information for marketing purposes to third party products or services.

This authorization ends:

☐ On (date): ___________ ☐ when the following event occurs: ________________________________
☐ In 90 days from the date signed *(if disclosure is to a financial institution or an employer of the patient for purposes other than payment)*

MY RIGHTS

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form: To receive research-related treatment in connection with research studies **OR t**o receive health care when the purpose is to create health care information for a third party.
I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by Palouse Medical/Pullman Readycare in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance.

TWO WAYS TO REVOKE THIS AUTHORIZATION ARE TO: Fill out a revocation form (available from Palouse Medical) or Write a letter to Palouse Medical.

PROTECTION AFTER DISCLOSURE:

I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

____

Patient or legally authorized individual signature **Date** **Time**

____

Printed name *(if signed on behalf of the patient)* **Circle Relationship** *(parent, legal guardian, personal representative)*

____

Minor patient's signature, if applicable ***Date*** ***Time***