Palouse Medical, P.S.
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PALOUSE MEDICAL P.S.
YOUR HEALTH PARTNER

825 SE Bishop Blvd., Suite 200 Pullman, WA 99163

Pullman ReadyCare
www.palousemedical.com

AUTHORIZATION TO REQUEST/DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

PREVIOUS NAME: _____

☐ **RECEIVE Protected Information From:** _____ **FAX #**_____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

☐ **SEND Protected Health Information To:** _____ **FAX #**_____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

MY AUTHORIZATION APPLIES TO ALL THE FOLLOWING HEALTH CARE INFORMATION: *(Please check all that apply)*

☐ **Two years health care information**

☐ Health care information in my medical record relating to the following treatment or condition(s):
_____

☐ 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
☐ Sexually Transmitted Diseases
☐ Mental Health or Illness
☐ Drug and/or Alcohol Abuse
☐ Reproductive Care *(minors only)*
☐ 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 ☐ For Portal Account Linking & Permission to Access Chart Information/Discuss with my Care Team ☐ Other_____

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** to 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 Signature *(or legally authorized individual)* **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***

_____