Authorization to Request/Disclose Protected Health Information

Palouse Specialty Physicians
Communities in Collaboration for Healthcare

Patient Name: _____

Date of Birth: _____ Previous name(s), if applicable: _____

The following authorization pertains to the following Palouse Specialty Physicians practices(s):

☐ **Palouse ENT & Audiology:** 825 SE Bishop Blvd, Ste. 601, Pullman, WA 99163 ● Phone 509-334-5876 ● Fax 509-332-8793

☐ **Palouse Urology:** 825 SE Bishop Blvd, Ste. 101, Pullman, WA 99163 ● Phone 509-332-3488 ● Fax 509-334-6477

☐ ***Records Request:*** I authorize the provider, facility or person below to release my medical records to Palouse Specialty Physicians.	☐ ***Records Release:*** I authorize Palouse Specialty Physicians to release my medical records to the provider/facility/person below.

Provider/Facility/Person Name: _____

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

Phone:_____ **Fax:** _____

I. MY AUTHORIZATION

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

- **o** All health care information in my medical record.
- **o** Health care information in my medical record relating to the following treatment or condition:

_____

- **o** Health care information in my medical record for the date(s): _____
- **o** Other (e.g., X-rays, bills), specify date(s): _____

USES AND DISCLOSURES REQUIRING SPECIFIC AUTHORIZATION

You may use or disclose health care information regarding testing, diagnosis, & treatment for (check all that apply):

o HIV/AIDS o Sexually transmitted diseases o Mental Health or Illness o Drug and/or Alcohol Abuse

Reason(s) for this authorization (check all that apply):

o at my request o Other (specify): _____

This authorization ends in 90 days from the date signed unless specifically stated below.

o on (date): _____ o when the following event occurs: _____

II. MY RIGHTS

1. 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 receive health care when the purpose is to create health care information for a third party.
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions already taken by Provider/Facility 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.
   - Write a letter to the above Provider/Facility you requested your medical records from.

III. PROTECTION AFTER DISCLOSURE

I understand that once 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 Relationship (parent, legal guardian, personal representative)