



1205 SE Professional Mall Blvd., Pullman, WA 99163
Phone (509) 332-2605 • Fax (509) 334-5754

Eastside Marketplace
1420 S Blaine St. Ste 5, Moscow, ID 83843
Phone (208) 882-2247 • Fax (208) 882-2292

Authorization to Release Health Care Information

Patient's Name: _____ Date of birth: _____

Current Address: _____

Previous Name: _____

I request and authorize: Name: _____

Address: _____

Phone or Fax: _____

To release health care information of the patient named above to:

Palouse Pediatrics
1205 SE Professional Mall Blvd, STE 104
Pullman, WA 99163

Palouse Pediatrics
1420 S. Blaine St, STE 5
Moscow, ID 83843

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: specify date(s): _____

Reasons for this authorization (check all that apply):

- At my request
- Leaving the area
- Changing physician

This authorization ends in 90 days from the date signed, or:

When the following event occurs: _____

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 understand I may revoke this authorization by:

- Fill out a revocation form. A form is available from Palouse Pediatrics.
- Write a letter

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

Printed name if signed on behalf of the patient

Relationship