Palouse Pediatrics
Health Care for Infants, Children and Adolescents

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

Authorization to Use or Disclose Protected Health Information

Patient's Name: _____ Date of birth: _____
Current Address: _____
Previous Name: _____

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): _____

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

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

You may disclose this health care information to:
Name (or title) and organization or class of persons: _____
Address: _____ City: _____ State: ____ Zip: _____
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 to **Palouse Pediatrics SE 1205 Professional Mall Blvd, Suite 104, Pullman, WA. 99163**

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Fees for copying records

I understand that I will provide this information within 3 business days from receipt of request, and I may be charged a fee for preparing and furnishing this information.

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

_____ _____
Printed name if signed on behalf of the patient **Relationship**