Gilman Family Practice Request for Records
1414 N Vercler Rd Bldg 4 · Spokane Valley · WA · 99216 · Phone · 509 924-4681 · Fax 509 922-7634

Authorization for Gilman Family Practice to Obtain or Disclose My Protected Health Information (PHI)

Patient Name:_____ Date of Birth:_____

Parent/Guardian:_____ Phone Number:_____

I request and authorize Gilman Family Practice to: _____ Obtain From or _____Release To

Physician/Provider: _____
Address: _____
City, State, Zip:_____
Phone: _____ Fax: _____

REASON FOR REQUEST: ____ personal _____Transfer of Care ____ Attorney ____Other (specify)_____

Please obtain or disclose the following health care information:

____ All health care information including chart notes, well visits, bone density, mammograms, colonoscopy, immunizations, EKG, Medication and Problem list for the last 3 years. I am transferring care.

____ Health care information for the following dates: _____ to _____

I understand that my medical record may include information regarding mental health treatment, Drug/Alcohol treatment, HIV/AIDS testing/treatment, Sexually Transmitted Infections (STI), genetic testing, or self-paid services. You are *specifically authorized* to release or obtain all information or medical records relating to such diagnosis, testing, or treatment unless specifically excluded below.

_____

MINORS AGE 12-17: A minor patient's signature is required to obtain private health information including: conditions relating to minor's reproductive care including but not limited to: contraception, pregnancy, and pregnancy termination, sterilization and STI (age 14 and older), alcohol/drug abuse (age 13 and older), and mental health conditions (age 13 and older).

I understand that I do not have to sign the authorization form in order to receive healthcare benefits, I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Gilman Family Practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. 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 Signature:_____ Date:_____

Parent of Legal Guardian Signature:_____ Date:_____

Relationship to patient if other than patient_____

(Authorization expires in 90 days unless otherwise specified) Specified Expiration Date___/___/___