Authorization to Release Patient Health Information

Kirkpatrick Family Care ♦ 1706 Washington Way ♦ Longview, WA, 98632 ♦ (360) 423-9580 ♦ www.kirkpatrickfamilycare.com

Please provide thorough and accurate information when filling out this form. Kirkpatrick Family Care will only process valid and complete Authorization forms.

PATIENT INFORMATION

Name _____ Date of Birth _____

Social Security # _____ Daytime Phone # _____

RELEASE INFORMATION FROM:

☐ Kirkpatrick Family Care

☐ All Medical Sources* 45 CFR 164.508(c)(1)(ii)

☐ Other:

Organization/Name _____

Address _____

City, State, Zip _____

Phone _____

Fax _____

RELEASE INFORMATION TO:

☐ Kirkpatrick Family Care

☐ Other:

Organization/Name _____

Address _____

City, State, Zip _____

Phone _____

Fax _____

TYPE OF INFORMTION TO BE RELEASED (I may be charged a reasonable fee to help cover the cost of copying and postage.)

☐ All Health Information

☐ Health Information related to the following treatment(s) or condition(s): _____

☐ Laboratory/Diagnostic Tests: _____

_____

☐ Other: _____

_____

The release of sensitive health information requires specific patient consent. If you would like to release this type information, please initial the following item:

_____ Drug/Alcohol Abuse

_____ Mental Health (including pain management or psychiatry records)

_____ Sexually Transmitted Diseases (including AIDS and HIV)

Purpose or Need for this Information: ☐ Transfer of Care ☐ Copies for Own Use ☐ Other: _____

I permit the information to be released for the specific purpose stated above. Any other use of this information without my written consent is prohibited.

I recognize that health information pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I realize that I have a right to a copy of this Authorization.

I am aware that the Authorization will expire in 90 days unless otherwise specified: _____ (date/event).

I understand that I may revoke or modify this Authorization at any time in writing, except to the extent that action has already been taken to comply with it.

I voluntarily sign this Authorization and understand that my health care will not be affected if I do not sign it.

By signing this document, I acknowledge that I have read and agreed to the Authorization's terms.

_____ _____ _____

Date ***Signature of Patient or Legally Responsible Party*** ***Authority to sign, if not Patient***

Name _____	**Date of Birth** _____

*** List of Medical Sources:**

1. Organization/Name _____
   Address _____
   City, State, Zip _____
   Phone _____
   Fax _____

2. Organization/Name _____
   Address _____
   City, State, Zip _____
   Phone _____
   Fax _____

3. Organization/Name _____
   Address _____
   City, State, Zip _____
   Phone _____
   Fax _____

4. Organization/Name _____
   Address _____
   City, State, Zip _____
   Phone _____
   Fax _____

5. Organization/Name _____
   Address _____
   City, State, Zip _____
   Phone _____
   Fax _____

6. Organization/Name _____
   Address _____
   City, State, Zip _____
   Phone _____
   Fax _____