Moscow Pullman OB/GYN

Ric Minudri, MD
Houng Trinh, MD
Nigel Campbell, MD
Julie Waite, ARNP

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name _____ Date of Birth _____

Current Address _____

SSN _____ Previous Name _____

I request and authorize _____ to release health care information of the patient named above to:

Name _____

Address _____Phone Number _____

City, State, ZIP _____Fax Number _____

Date records are needed by _____ Ok to FAX (circle one) YES NO

This request and authorization applies to:

____ All Health Care information
____ Health Care information relating to the following treatment, condition, or dates of treatment: _____
_____
____ Other _____

Reason for requesting records:

____ Changing physicians
____ Leaving the area
____ Consultation with specialist
____ Request from school/college or employer
____ Request from insurance company

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated fro HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis testing or treatment.

_____ _____
Signature of patient or patient's authorized representative *Date Signed*

_____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

Authorization expires 90 days after the date it is signed

MEDICAL REQUEST FOR RECORDS WILL BE COMPLETED IN 14 WORKING DAYS

PULLMAN
1205 SE Professional Mall Blvd.
Suite 102
Pullman, WA 99163
509-332-7511
Fax 509-334-4712

MOSCOW
623 South Main Street
Suite 5
Moscow, ID 83843
208-883-0813
Fax 208-882-8319