

Authorization for TFPC to Email Health Care Information

Please print clearly. If portions of this form are illegible it may delay or impede processing.

Patient Name: _____

Date of Birth : _____

Previous Names: _____

SSN (optional): _____

You may use or disclose the following health care information (please check one box)

- All health care information in my medical records.
- Specific information regarding the following issue(s) or date(s): _____

I understand that my consent is required to release any health care information relating to testing, diagnosis, and/or treatment of HIV/AIDS, STDs, Mental Health, Genetic Testing and drug/alcohol use and/or abuse. TFPC is specifically authorized to release all health care information relating to such diagnosis, testing or treatment unless specified below.

DO NOT release information regarding: _____

I request and authorize:

To email the records specified above to:

Tumwater Family Practice Clinic
 Phone: (360) 754-6367 Fax: (360) 754-6429
 Email Address: MedicalRecords@tfpclinic.com

Name: _____
 Email Address: _____

Please note that Tumwater Family Practice does not have encrypted email. Requesting your records via unencrypted email carries a degree of risk as there is potential for unauthorized access during electronic transit. By signing this authorization you are agreeing to accept that risk.

Reason(s) for this authorization: At my request Changing Primary Care Providers Other _____

This authorization will expire _____ (90 days from signature if no expiration is specified).

I understand I do not have to sign this authorization in order to get health care benefits.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken based upon this authorization. To revoke this authorization contact TFPC to fill out a revocation form.

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

If the information disclosed from TFPC was not generated by a provider of this clinic we will not be liable for the contents of those records.

Patient or legally authorized individual signature

Date

Printed Name

Relationship (parent, self, etc.)