Authorization for TFPC to Receive Health Care Information from Prior Providers

Patient Name: _____ Date of Birth: _____

Previous Name: _____ SSN (Optional): _____

I authorize Tumwater Family Practice Clinic to acquire records from my previous providers listed below.

Records may be faxed or mailed to:
Tumwater Family Practice Clinic
150 Dennis St SW
Tumwater, WA 98501
Phone: (360) 754-6367 Fax: (360) 754-6429

Please do not send records on CD

Please send:

☐ All health care information in my medical records, this includes HIV/STD/Psych/Drug/Alcohol

☐ Specific Information regarding: _____

The Following Providers are authorized to release my records:

Clinic/Provider Name:_____
Address:_____
City:_____ State:____ Zip:_____
Phone:_____ Fax:_____

Clinic/Provider Name:_____
Address:_____
City:_____ State:____ Zip: _____
Phone:_____ Fax:_____

Clinic/Provider Name:_____
Address:_____
City:_____ State:____ Zip:_____
Phone:_____ Fax:_____

Clinic/Provider Name:_____
Address:_____
City:_____ State:____ Zip: _____
Phone:_____ Fax:_____

This authorization will expire once the requested information is received.

This authorization is for continuity of care but 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 or any of the above listed clinics 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.

Please note: If the patient is 12-17 years old both the patient and the parent must sign.

_____ _____
Patient Signature Date

_____ Self
Printed Name Relationship

_____ _____
Parent or legally authorized individual Signature Date

_____ Self
Printed Name Relationship

Revised date: 02/24/2017