Authorization for TFPC to Disclose Health Care Information

Patient Name: _____ Date of Birth :_____

Previous Names: _____ SSN:_____

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:

Tumwater Family Practice Clinic
150 Dennis St SW
Tumwater WA, 98501
Phone: (360) 754-6367 Fax: (360) 754-6429

To release the records specified above to:

Name:_____
Address:_____
City: _____State:____ Zip:_____
Phone:_____ Fax:_____

Reason(s) for this authorization: ☐ At my request ☐ Changing Primary Care Providers ☐ Other_____

This authorization will expire in 90 days or upon completion.

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.)**

Revised date: 4/24/2013