 Acct #: _____

DOB: _____/_____/_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This authorization grants permission for the party (parties) named below to: have access to medical information, laboratory results, test findings, and telephone communication; pick up medications, referrals, and notes; be made aware of my diagnosis, prognosis, and treatment plans; and have access to my financial information. Also included is an authorization to leave similar medical information on a private phone or voice messaging system. I understand this authorization is voluntary.

Patient Name:_____ DOB:_____

Select one of the following:

☐ I **DO NOT** authorize Rocky Run Family Medicine to release the above patient's information to anyone else nor have any number on record for leaving detailed messages.

☐ I request and authorize **Rocky Run Family Medicine** to release healthcare information of the above patient to the following listed members.

- Name: _____ Relationship to patient: _____
- Name: _____ Relationship to patient: _____
- Name: _____ Relationship to patient: _____
- Private number/voicemail on which messages may be left (can be own #): (_____)_____-_____

If authorization is granted, please fill below. Otherwise, skip to the bottom of the page and sign.

1. I request that the authorization granted to the above members (select one):
   - ☐ Is effective for the **lifetime** of the patient unless revoked in writing
   - ☐ Expires **1 year** from today's date
   - ☐ Is effective until: _____
2. This request and authorization applies to (select one):
   - ☐ All healthcare information
   - ☐ Healthcare information only related to the following condition, treatment, or date range:
     _____
   - ☐ Other criteria: _____
3. **Other records:** Sexually Transmitted Diseases (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papillomavirus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

   ☐ Yes ☐ No I authorize the release of any STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.

   ☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient/Guardian Name: _____ Signature: _____