RRFM Document #NYD0322 Name / Acct #: _____DOB: _____/_____/_____

Patient Information and Authorization Release

Patient Name: _____ Date: _____

Address:_____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ Email: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partnered ☐Other

Emergency Contact: _____ Phone: (_____)_____-_____ Relation: _____

Preferred Pharmacy: _____ Location: _____ Phone: (_____)_____-_____

Primary Insurance Information

Carrier: _____ Member ID#: _____ Group#: _____

Name of policyholder (if other than self): _____DOB: _____

Address **(If different)**: _____

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 diagnoses, prognoses, and treatment plans; and have access to my financial information.

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

☐ I authorize **Rocky Run Family Medicine** to release healthcare information of the patient to

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

1. I request that the authorization granted to the above members (choose 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
   - ☐ Other criteria: _____
3. **Other records:** STDs, as defined by law, RCW 70.24 et seq., include herpes, herpes simplex, human papillomavirus, warts, genital warts, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV, AIDS, and gonorrhea.
   - ☐ I authorize the release of any STD results to the person(s) listed above.
   - ☐ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient/Guardian Name: _____ Signature: _____