Plumtree Family Health Center

AUTHORIZATION FOR PLUMTREEE FAMILY HEALTH CENTER

TO RELEASE HEALTHCARE INFORMATION TO ANOTHER PARTY

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize Plumtree Family Health Center to release healthcare information of the patient named above to:

Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip Code: ______________

Phone: ______________________ Fax: ______________________(required)

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

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☐ All healthcare information - # of years records ___________

☐ Other: ______________________

*****RECORDS FEE:** There will be a fee of 76 cents per page when records are copied for the patient. We also charge a preparation fee of $22.88 when records are provided directly to another healthcare provider. You may also provide our office with a BRAND NEW UNOPENED USB drive and we can transfer the records to the USB drive for a flat fee of $20.00. Please indicate which method you prefer below:

☐ Printed – 76 cents per page

☐ USB DRIVE- 20.00 (must provide a brand new unopened USB or purchase one for $10.00 from our office)

☐ Chart Summary Sent to Another Provider (Med List, Last Office Visit Note, Last Labs)- Free

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

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

Patient Signature: ______________________ Date Signed: ______________________

This request is valid for 2 years after signed. Patient may revoke the authorization at any time. Requests to revoke this authorization may be made by phone or letter.