YELM FAMILY MEDICINE, PLLC

Authorization to Use or Disclose Protected Health Information

****PLEASE ATTACH THIS PAGE WHEN SENDING OR FAXING RECORDS****

Patient's Name: _____ **Birth Date:** _____

Previous Name: _____ **Phone**: _____

Address: _____

Release: □ From □ To	**Release: □ From □ To**
YELM FAMILY MEDICINE	Facility:
201 Tahoma Blvd SE STE 102	Address:
Yelm, WA 98597	
(PH) 360-458-7761	Phone:
(FAX) 360-706-1183	Fax:
	Email:

Purpose of Request: □ Transfer of Care □ Personal □ Physician Request □ Insurance □ Legal □ Other

Information Requested:

- □ Medical Records from Last 3 Years
- □ Including Summary of Care (Immunization, Radiology Reports, Medication list, Problem list, Labs)
- □ Including Records regarding the following Treatments: _____
- □ Health Care information in my Medical Records for the Date(s): _____
- □ Other: _____

Patient Rights

I understand that I do not have to sign this authorization to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). I may revoke this authorization in writing at any time. To view the process for revoking this authorization, please read the Notice of Privacy Practices to patients posted at the facility where your information is being released. Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it. I understand that this authorization will expire 90 days from the date signed.

Uses and Disclosures Requiring Specific Authorization

Please check the following if you wish to have them <u>EXCLUDED</u> from your medical records disclosure:

- □ HIV/AIDS
- □ Mental Health or Illness
- □ Reproductive Care (minors only)
- □ Sexually Transmitted Diseases
- □ Drug and/or Alcohol Abuse

<u>Minors – a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).</u>

_____

Patient or legally authorized individual signature Date Time

_____

Printed name (If signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)

_____

Minor patient's signature if patient is over the age of 13 (**Signature Required**) Date Time **Revised Nov 2025**