CREELMAN FAMILY PRACTICE PLLC

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AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

PATIENT IDENTIFICATION:

Patient Name: (please PRINT) _____

Birthdate: _____ SS#: _____

RELEASE INFORMATION FROM:

Provider/Facility: _____

Address: _____

City,State,Zip: _____

Phone: _____

DISCLOSE INFORMATION TO:

Recipient: CREELMAN FAMILY PRACTICE PLLC

Address: 712 S. BURLINGTON BLVD.

City,State,Zip: BURLINGTON, WA. 98233

Phone: (360) 757-0027 Fax: (360) 757-3698

MY AUTHORIZATION :

Release the Following Health Care Information:

- ☐ The most recent 2 years of pertinent information (chart notes, labs, x-rays, special tests)
- ☐ All health care information in my medical record
- ☐ Health care information relating to the following condition: _____
- ☐ Health care information for the following dates: _____
- ☐ Other: _____

Exclude the Following Information from Release:

☐ HIV (AIDS virus) ☐ Sexually transmitted diseases ☐ Psychiatric disorders/mental health ☐ Drug and/or alcohol use

Purpose for Disclosure:

☐ Doctor ☐ Attorney ☐ Insurance ☐ Personal

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. Revocation would not affect any actions already taken by the practice/facility based upon this authorization. Once health care information is disclosed, the person or organization receiving the information may re-disclose it. Privacy laws may no longer protect it. This authorization will expire 90 days from the date signed. A possible copying fee may be required.

Signature _____ **Date** _____
Patient or legally authorized individual

Printed Name _____ **Date** _____

If signed on behalf of the patient **Relationship** _____ CFP 5/26/16