Gilman Family Practice Request for Records

1414 N Vercler Rd Bldg 4 · Spokane Valley · WA · 99216 · Phone · 509 924-4681 · Fax 509 922-7634

MEDICAL RELEASE AUTHORIZATION

I _____ Authorize my previous Physician/Provider
(print full patient name)

to RELEASE Protected Health Information to Gilman Family Practice (GFP).

Previous Physician/Provider: _____
Address: _____
City, State, Zip:_____

Patient's Name:_____
Patient's Date of Birth_____ Patient's Age_____
(If Minor, see Consent of Minor)

READ CAREFULLY: I understand that my consent is required to release Protected Health Information related to testing, treatment, and/or diagnosis to GFP. The above-named Physician/Provider is specifically authorized to release all protected health information to the Gilman Family Practice unless specifically excluded.

Example of exclusions: Sexually Transmitted Diseases, Drug/Alcohol Abuse, Mental Health Treatment

*EXCLUDE*_____

THIS PORTION WILL BE COMPLETED BY GILMAN FAMILY PRACTICE.
Please Send: ☐Encounter Notes☐Radiology Results☐Immunizations☐EKG ☐Colonoscopy ☐Med List ☐Problem list
Include the last ___years. Please include the following records: _____
(Please explain)

(Our Practice does not subscribe to a secure encrypted email service. Our email does not meet the level of security necessary to send Private Health Information. You can mail or fax PHI to 509 922-7634)

THIS PORTION NEEDS TO BE COMPLETED BY THE MINOR PATIENT.
CONSENT OF MINOR (ages under 17): In accordance to Washington State Law, I understand that I am entitled to confidential treatment of information relating to treatment of:

No Age Limit	Age 13 and Older	Age 14 and Older
• Contraception	• Drug/Alcohol Abuse	• Sexually Transmitted Diseases
• Pregnancy Termination	• Mental Health Treatment	
• Sterilization/Reproduction		

Pursuant to Washington Law RCW70.SEQ, RCW71.SEQ, State v. Koome

*All minor persons married to a person of full age shall be deemed and taken to be full age.
*Gilman Family Practice reserves the right to seek an attorney's opinion to interpret these statutes.
I understand that my signature below will authorize release of this information, *unless specifically excluded.*
*EXCLUDE*_____

Signature of Minor Patient_____DATE_____

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Gilman Family Practice based upon this authorization. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

AUTHORIZATION SIGNATURE_____DATE:_____
(SIGNATURE PATIENT OR GUARDIAN)

(Authorization expires in 90 days unless otherwise specified) Specified Expiration Date___/___/___