Palouse Heart Center
Palouse Pediatrics
Palouse Psychiatry & Behavioral Health
Palouse Pulmonology & Sleep Medicine
Pullman Family Medicine
Palouse Health Center

Permission to Access Medical Records

Patient Name: _____ Date of Birth: _____

By my signature on this form, I authorize access for the following individual(s) to the following areas of my medical records until _____.
(Month/Day/Year)

If I choose to end this consent before the expiration date, I understand that I must contact the respective clinic of Pullman Regional Hospital Clinic Network to make any edits to access or to revoke consent entirely.

Name	**Phone Number**	**Relationship**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Please initial each area this access includes:

_____Appointment Information
(Initial)
_____Billing & Payment Information
(Initial)
_____Health Information from other providers
(Initial)
_____Diagnosis
(Initial)
_____Treatment
(Initial)
_____Symptoms
(Initial)
_____Test Results
(Initial)

Under Washington Law, the following areas of the medical record require specific authorized consent. Please initial below to authorize access to these protected areas of your medical record if you wish for them to be included in this authorization.

_____ Mental Health/Psychiatric Disorders/Depression/Anxiety
(Initial)
_____ Sexually Transmitted Infections (STI): Testing, Results, Treatment, or Symptoms
(Initial)
_____ HIV/AIDS Virus: Testing, Results, Treatment, or Symptoms
(Initial)
_____ Substance Abuse/Use, Drug and/or Alcohol Abuse/Use
(Initial)

I acknowledge I have read and understand the contents of this document and that my signature is made voluntarily, of my own free will.

_____ _____
Printed name of patient Date of Birth

_____ _____
Patient Signature Date Time