Family Wellness Center, PC www.familywellnesscenter.com
1000 SE Tech Center Drive #120, Vancouver WA 98683 **P: (360) 260-2773 Fax: (360) 260-2217**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

******Please allow 10 business days for this request to be processed***

Patient Name (Full): ________________________________ Date of Birth: ______________
AKA (Also known as): ______________________________ Phone # __________________

Authorizes the Family Wellness Center, PC, to ***release the following medical information to:***

NAME: ____
Address: ____
City _______________________ **State:**____ **Zip:** ___________
Phone #: ____

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition, or dates of treatment: ____
_____ ALL health care information
_____ Other: ____

____ I wish to receive **paper records** for myself of the specific requested information for a **$6.50 fee** (200 pg max). Fee includes all labor, copying supplies, and postage if applicable (USPS to 48 states only).

____ I wish to receive a complete ELECTRONIC copy of all of my health care information on a **CD/DVD** for a **$6.50 fee**. Fee includes labor, cost of CD/DVD, and postage (USPS to 48 states only).

____ I wish to receive a complete ELECTRONIC copy of all of my health care information on a **USB drive** for a **$10.00 fee**. Fee includes labor, cost of USB 2 GB+ drive, postage (USPS to 48 states only).

Reason for Request: ______Moved ______Change of Insurance ______Closer Location to Work/Home
______Dissatisfied with Customer Service ______Dissatisfied with Medical Staff Other____________________

This authorization is valid for 120 days from the date of signature and there may be fees to process it. The patient can revoke this authorization at any time by notifying the Family Wellness Center, PC in writing. This would not affect any actions already taken by the Family Wellness Center based upon this authorization. I understand that I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment or enrollment or eligibility). However, I do have to sign this release to receive health care when the purpose is to create health information for a third party or take part in a research study.

Any Protected Health Information (PHI) received by a patient (parent or legal guardian) via a signed records release in any format -- paper, electronic download via the internet, and/or electronic copy via CD -- is no longer the responsibility of the Family Wellness Center. The security of that information passes to the patient and/or his or her representative once in possession of the PHI.

I understand that the information disclosed may contain matter that is protected by Federal and State laws, including information which may relate to Alcohol and/or Drug Treatment, Mental Health, AIDS and/or HIV Testing and/or other sexually transmitted diseases. I UNDERSTAND THIS INFO WILL BE RELEASED UNLESS I SPECIFICALLY REQUEST THAT IT BE WITHHELD.

____ ____________________________________
Signature of patient or patient's authorized representative Date signed
Relationship if signed by anyone other than patient (parent, legal guardian, etc.) ____________________________

Consent of Minor: A minor patient's signature is REQUIRED in order to release information for the following: Alcoholism/Chemical dependency and Sexually Transmitted Diseases, including HIV/Aids test results **(AGE 14 and older).** REQUIRED to release Mental Health / Psychiatric information **(AGE 13 and older).**

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*Signature of Minor Patient Date Signed Age when signed