Family Wellness Center, PC
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

AKA: _____ Phone #_____ Alternate Phone# _____

I request and authorize (**previous Doctor - please include address and phone number**)
_____
_____
_____
to release health care information of the patient named above to:

☐ Thomas Dyehouse, M.D. ☐ Teresa Hildebrand, M.D. ☐ Stephanie Bennett, FNP
☐ Karli Whittam, M.D. ☐ Susan Oshiro-Zeier, FNP ☐ Cathleen O'Farrell, M.D.

FAMILY WELLNESS CENTER, P.C.
1000 SE Tech Center Drive Suite # 120
VANCOUVER, WA 98683
Phone: 360-260-2773 FAX: 360-260-2217

This request and authorization applies to:
_____ Health care information relating to the following treatment, condition or dates of treatment:
_____

_____ All Health Care information

_____ Most Recent Chart Notes, **Last Physical** (visit notes & labs) or **Last Well Child Check** (visit notes, current immunization record & growth chart), **recent** diagnostic studies (ie. MRI, CT's, labs) and consult notes.

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 it to receive health care when the purpose is to create health information for a third party or take part in research study. Once health care information is disclosed, the person or organization that receives it may re-disclose it. The Privacy laws may no longer protect it.

I understand that the information disclosed may contain matter that is protected by Federal and State laws, including information which may relate to ALCOHOL, DRUG, AND PSYCHIATRIC TREATMENT, MENTAL HEALTH, AIDS AND/OR HIV TESTING AND/OR OTHER SEXUALLY TRANSMITTED DISEASES. I UNDERSTAND THIS INFORMATION 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).**

*Signature of Minor Patient Date Signed Age when signed