FAMILY HEALTH CENTERS
YOUR FAMILY, YOUR HEALTH, YOUR CHOICE
P.O. Box 1340 | Okanogan, WA 98840 www.myfamilyhealth.org

Authorization for Use or Release of Protected Health Information

Patient: _____ **DOB:**_____

Please disclose the following information:
___ Past 2 years of pertinent information-chart notes, labs, x-rays & special tests
___ All medical records
___ Specific Information-Please specify:_____

*****The following items must be initialed to be *excluded* in the use and/or disclosure of other protected health information*****
____ HIV/AIDS/STD related information and/or records ___ Mental health notes and/or records
____ Drug/Alcohol use ___ Genetic Testing

Reason for release: _ Doctor _ Personal _ Attorney _ Insurance _ Transfer of Care

To be released from (name of provider or facility)**:** _____
City/State_____ Phone:_____ Fax:_____

And sent to (name of provider or facility):_____
Address/City/State_____
Phone:_____ Fax:_____

Please check what kind of files you prefer: __No format preference __Paper or fax
___ Thumb drive/cd-rom or Secure Email (email address needed)_____

Expiration date for this request: _____ (Document will expire in 90 days if date is left blank) This consent may be revoked at any time by written notice to PO Box 1340 Okanogan, WA 98840

I understand that electronic media and delivery methods pose certain risks to the privacy and security of my protected health information that may be beyond the control of Family Health Centers.

_____ _____ _____
Patient or Legally Responsible Person Relationship to the patient Date

Effective 3/7/22