

Moscow-Pullman OB/GYN

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Authorization to release Health Care Information

Patient's Name _____ Date of Birth _____

Current address _____

SSN _____ Previous name _____

I request and authorize _____ to release health care information of the patient named above to:

Name _____

Address _____

City, State, ZIP _____

Date records are needed by _____ Ok to FAX (circle one) YES NO

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____ All health care information

_____ Other _____

Reason for requesting records:

_____ Changing physicians

_____ Leaving the area

_____ Consultation with specialist

_____ Request from school/college or employer

_____ Request from insurance company

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis testing or treatment.

Signature of patient or patient's authorized representative

Date Signed

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

Authorization expires 90 days after the date it is signed

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