LIBERTY LAKE
DIRECT PRIMARY CARE
2207 N. Molter Rd. Ste 203 Liberty Lake, WA 99019
Phone: 509.348.2214 | Fax: 509.903.0040

# AUTHORIZATION TO DISCLOSE PERSONAL HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____
Previous Name (if any): _____
Address: _____
City_____ State _____ Zip_____

I request and authorize **Liberty Lake Direct Primary Care** to disclose personal health information regarding the above-named patient, including health status, medical records, laboratory results, radiologic testing results, medications, hospitalization information, office notes and treatment plans to the following individual. I understand that this authorization will expire in 3 years and may be revoked at any time in writing.

| | | |
|---|---|---|
| Recipient's Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | |

Purpose of request:
_____

This request and authorization applies to:
☐ All healthcare information
☐ Other: _____

I acknowledge that these records may include sensitive material. Therefore, I request that you *include* the following records if any (initial by categories to be included in records provided):

____HIV/AIDS/STI ____Genetic testing ____Mental health information.
____Substance use disorder diagnosis, treatment, or referral information.

Patient or Representative Signature: _____ Date: _____
Description of patient representative authority (i.e., parent): _____