Kimberley D Blewett, DO
Craig Cox, MD
Jo Elsbury, MD
Sunday D Henry, MD
Sara M Lawrence, MD
Randall G Lorenz, MD
Vicky Lott, MD
Raymond M Paz, MD
Wayne L Ruby, MD

moscow family medicine

"Improving the Quality of Your Life"

Helen M Shearer, MD
Francis K Spain, MD
Robert M Ting, MD
Dustin K Worth, DO
Don Bickford, PA-C
Joanne L Braun, FNP
Steven Fischer, PA-C
Terri Grzebielski, PA-C

Request for Release of Medical Information

Patient Information: Name: _____

Birthdate: _____ Age: _____

SSN#:_____ Ph. #: _____

I do not wish to release my medical information to anyone _____

Provide My Medical Information Upon Request To:

Name	Date of Birth	Social Security Number	Relationship to Patient

****If requesting a patient portal family account "all records" and "all dates" must be checked****

The information that I request to be released is:

- ❒ **ALL RECORDS**
- ❒ EKG Reports
- ❒ Laboratory Results
- ❒ Psychotherapy notes _____ Initial
- ❒ Progress Notes Only
- ❒ Imaging Reports
- ❒ History & Physical Exam Note
- ❒ AIDS/HIV/STD Information

The time period of records I request to be released includes:

❒ **ALL DATES** ❒ From _____ to _____

Purpose of release: ❒ **PERSONAL USE** ❒ Attorney/Legal request ❒Other_____

I authorize the release of information as described above from Moscow Family Medicine. This authorization will expire **one year** from the date signed below, unless I revoke it earlier. I can revoke it by signing a corresponding revocation of authority. I understand that information I authorize to be released may be subject to redisclosure by the recipient.

If the patient is aged 14 years or older, only the patient may authorize release and/or disclosure of information related to sexually transmitted disease. I understand that my signature below authorizes release of this information. Authorization is valid for 1 year unless revoked earlier, and I can revoke this authorization by signing a corresponding revocation of authority. I understand that information I authorize to be released may be subject to redisclosure by the recipient.

_____

Patient or Guardian Signature **Date**

Relationship to Patient _____

_____ _____

Minor Aged 14-17 Signature **Date**