Permission to Access Medical Records

I, ___________________________________, allow ____
(Printed Name of Patient) (Full Name & Relationship to Patient)

to access my medical records until ____________________. If I choose to end this consent before the
(Month/Day/Year)

expired date, I must contact Pullman Family Medicine and ano6ther form must be completed.

Please initial each area this access includes:

_____Appointment Information
(Initial)

_____Billing & Payment Information
(Initial)

_____Health Information from other providers
(Initial)

____Diagnosis
(Initial)

______Treatment
(Initial)

______Symptoms
(Initial)

______Test Results
(Initial)

Under Washington Law, the following areas of the medical record require specific authorized consent. Please initial below to authorize access to these protected areas of your medical record if you wish for them to be included in this authorization.

____Mental Health/Psychiatric Disorders/Depression/Anxiety
(Initial)

___Sexually Transmitted Disease (STD): Testing, Results, Treatment, or Symptoms
(Initial)

___HIV/AIDS Virus: Testing, Results, Treatment, or Symptoms
(Initial)

___Substance Abuse/Use, Drug and/or Alcohol Abuse/Use
(Initial)

Below must be signed in front of a clinic staff member.

By signing this form, I acknowledge that this is optional and I am doing this of my own free will.

_____________________________________ _________________
Printed name of patient Date of Birth

_____________________________________ _____________________________________
Patient Signature Date Time

___________________________________ _____________________________________
Clinic Staff Witness-Printed Name Date Time