

**Family Wellness Center, PC**  
**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

AKA: \_\_\_\_\_ Phone # \_\_\_\_\_ Alternate Phone# \_\_\_\_\_

I request and authorize (**previous Doctor - please include address and phone number**)

\_\_\_\_\_  
\_\_\_\_\_

to release health care information of the patient named above to:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Susan Hughes, M.D.     | <input type="checkbox"/> Teresa Hildebrand, M.D. | <input type="checkbox"/> Stephanie Bennett, FNP |
| <input type="checkbox"/> Tom Dyehouse, M.D.     | <input type="checkbox"/> Morgan Powell, FNP      | <input type="checkbox"/> Karli Whittam, M.D.    |
| <input type="checkbox"/> Jeffrey S. Young, M.D. |  |   |

**FAMILY WELLNESS CENTER, P.C.**  
**1000 SE Tech Center Drive Suite # 120**  
**VANCOUVER, WA 98683**  
**Phone: 360-260-2773 FAX: 360-260-2217**

**This request and authorization applies to:**

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

\_\_\_\_\_

\_\_\_\_\_ All health care information

\_\_\_\_\_ Other: \_\_\_\_\_

This authorization is valid for 120 days from the date of signature and there may be fees to process it.

The patient can revoke this authorization at any time by notifying the Family Wellness Center, PC in writing. This would not affect any actions already taken by the Family Wellness Center based upon this authorization.

I understand that I do not have to sign this authorization in order to obtain healthcare benefits (treatment, payment or enrollment or eligibility). However, I do have to sign it to receive health care when the purpose is to create health information for a third party or take part in research study.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. The Privacy laws may no longer protect it.

I understand that the information disclosed may contain matter that is protected by Federal and State laws, including information which may relate to ALCOHOL, DRUG, AND PSYCHIATRIC TREATMENT, AIDS AND/OR HIV TESTING AND/OR OTHER SEXUALLY TRANSMITTED DISEASES. I UNDERSTAND THIS INFORMATION WILL BE RELEASED UNLESS I SPECIFICALLY REQUEST THAT IT BE WITHHELD.

\_\_\_\_\_  
Signature of patient or patient's authorized representative

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Relationship if signed by anyone other than patient (parent, legal guardian, etc.)