SEL HEALTH CLINIC
2560 NE Hopkins Court, Pullman WA 99163
Phone: 509.338.3800
Fax: 509.339.2702

Date of upcoming appointment:
_____/_____/_____
STAT Request please

Authorization for Use and Disclosure of Protected Health Information

1. I authorize the following disclosure of my protected health information.
2. I may revoke the authorization at any time by providing a written statement to SEL Health Clinic. (The revocation will not impact protected health information already released while my permission was in effect. However, further release of that health information will be prohibited without my specific authorization).
3. My treatment will not be conditioned on whether I sign this.
4. Once my protected health information is disclosed, it may no longer be protected by federal or state law and may be re-disclosed to other parties (however the SEL Health Clinic will not release protected health information without patient authorization).
5. Release of protected health information **from**: (Office name and city/state):
   _____
6. Office name and city/state to **receive** protected health information:
   SEL Health Clinic, 2560 NE Hopkins Court, Pullman WA 99163, **Fax #: 509-339-2702**
7. Purpose of disclosure: _____
8. Please release the following protected health information (check those that apply):

   _____ Last two years

   _____ Other records (describe or list beginning and ending dates below):

   Beginning date of requested records: _____

   Ending date of requested records: _____

   Please circle the following: Imaging Procedures Labs Immunizations

   Expiration date of authorization: _____ (If no date is filled in, this authorization shall expire one year from the Date of Request unless revoked sooner.)

*Specific healthcare records require your **initials** for authorization, otherwise they are excluded from the information released. Please specially authorize the following information to be included in this medical release:

_____HIV (AIDs Virus) _____Psychiatric/Mental Health

_____Sexually Transmitted Disease _____Drugs and/or Alcohol use

Date of Request: _____ Date of Birth: _____

Print Patient Name: _____ Patient Signature: _____

Parent/Guardian Name: _____ Parent/Guardian Signature: _____

Original 05/2017 - Updated 12/2022 * You may revoke this authorization in writing.

OUR CLINIC DOES NOT ACCEPT RECORDS ON CD'S OR FLASHDRIVES. IF OVER 50 PAGES, PLEASE MAIL RECORDS.