Franklin Park Urgent Care Center

Phone:(509)489-1150 Fax:(509)482-6010

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I **Request** and **Authorize** the release of medical records for:

Patient Name	Birth Date	Previous Name
_____	_____	_____

To Be Released FROM/TO (circle one): **Franklin Park Urgent Care Center**
5904 North Division Street
Spokane, WA 99208

And Sent TO/FROM (circle one):

Name	Organization
_____	_____

Address	City / State / Zip	Fax Number
_____	_____	_____

Please Mail / Fax (circle one)

For the Purpose of: _____

This Request and Authorization Applies to:

- All healthcare information
- Healthcare information relating to the following treatment or condition from: _____ to _____
- Other: _____

This Consent Expires 90 Days from the Date of Signature

Patient or Legally Responsible Person	Relationship
_____	_____

Witness to Signature	Date
_____	_____

FEDERALLY PROTECTED INFORMATION

I specifically authorize the release of information pertaining to the testing, diagnosis and/or treatment of psychiatric disorders/mental health, alcohol/drug use, sexually transmitted diseases or HIV/AIDS, if such is part of my record.

For the Purpose of: _____

Patient or Legally Responsible Person	Relationship
_____	_____

Witness to Signature	Date
_____	_____