SUMMIT THERAPY & HEALTH SERVICES

CENTERED ON EXCELLENCE

Pullman Feeding Team for Children

Authorization for Pullman Regional Hospital/ Summit Therapy and Health Services to Use and Disclose My Health Care Information

Patient's Name: _____ **Date of Birth:** _____/_____/_____

Parent/Caregiver: _____

Address:_____ _____ _____ _____
State Zip Code

Phone Number: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

( ) Evaluation and treatment results and recommendations; progress notes and reports

( ) Health care information in my medical record relating to the following treatment or condition:

_____

Persons/Organization providing information:

Pullman Feeding Team for Children
1620 SE Summit Ct Pullman, WA 99163

Persons/Organization receiving information include the following:
__Boost (Early Intervention) __Pullman School District ___Latah Early Intervention
___Gritman Medical Center, WIC ___ , Daycare Provider (_____)
specify
__Other _____

This authorization ends (this document does not permit disclosure of health information created more than 90 days after the date is signed):

Check one:

( ) In 90 days from the date signed

( ) On (date): _____/_____/_____

( ) Other_____

Revised: 04/12/17

II. My Rights:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study; or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Pullman Regional Hospital Summit Therapy based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke by:

- Filling out a revocation form (available from Pullman Regional Hospital Summit Therapy); or
- Writing a letter to Pullman Regional Hospital.

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

_____	_____/_____/_____	_____
Patient or legally authorized individual signature	Date	Time

_____	_____
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, representative, etc.

_____	_____/_____/_____	_____
Witnessed by	Date	Representative Initials