

Vista Family Health

CONSENT FORM TO OBTAIN CONFIDENTIAL MEDICAL INFORMATION

I, _____ DOB: _____
Patient's legal name

Request and authorize the following to release medical information:

FROM: (WHERE RECORDS CURRENTLY ARE)	TO (WHERE YOU WANT RECORDS TO GO)
Name of Organization: _____	Name of Organization: VISTA FAMILY HEALTH
Address: _____	Address: 7201 W. GRANDRIDGE BLVD SUITE 101
City: _____ ST: _____ Zip: _____	City: KENNEWICK ST: WA Zip: 99336
PH: _____ Fax: _____	PH: 509-735-2325 Fax: 509-735-3222

INFORMATION TO BE RELEASED:

_____ The most recent 2 yrs of pertinent information (Prog notes, x-rays, labs and special tests)
_____ All medical records within the 5 yrs
_____ Specific Information i.e.: labs, x-rays, ect: _____
Dates please

I realize that my specific consent is required to release certain information that may be in my record. I specifically authorize the release of the following information: Please Initial

SEXUALLY TRANSMITTED DISEASE _____ DRUGS/ALCOHOL HISTORY _____
MENTAL HEALTH/PSYCHIATRIC DISORDERS _____ HIV/AIDS INFORMATION _____
PHYSICAL ABUSE _____ OTHER _____

Signature: _____ Date: _____

This authorization expires 90 days after the date signed