Lustig Health and Wellness Center
Tabitha Lustig ARNP, FNP-BC
1950 Keene Rd BLDG J Richland, WA 99352
Phone: (509) 943-6800 Fax: (509) 491-3900

Request for Medical Information

This Health form & Wellness is required for obtaining your medical information. By submitting this form you are authorizing Lustig Health and Wellness Center to receive your medical records or other information from the sources referenced below. We value your privacy and want you to be informed of how we may use and disclose your protected health information. For specifics about our policies, read our Privacy Statement.

Patient Information
Full Name:_____
Date of Birth:__/__/____
Phone Number: (___) ___-____

Release of Medical Information Form

Provider Name:_____
Facility Address:_____
Phone: (___) ___-____ Fax: (___) ___-____

Select the Information you would like to disclose (please initial on lines)
_____Disclose 2 years medical information and pertinent health information
_____Disclose information provided from other sources
_____Only medical records specifically pertaining to _____

I understand and agree that the information below will be disclosed if I place my initials in the applicable space next to the type of information.
____ HIV/AIDS testing/treatment ____ Mental Health ____Genetic Testing ____Drug/Alcohol

I authorize the release of my protected health information.
Patient Signature:_____ Date:__/__/____
Authorized Signature:_____Date:__/__/____
Relationship:_____

I understand that I have the right to revoke this authorization, in writing at any time by sending a written notification to the Medical Records Department, at Lustig Health & Wellness, 1950 Keene Rd Bldg J, Richland WA 99352. This authorization shall expire 6 months from the date issued. If you have any questions regarding this release of protection information, contact (509) 943-6800.