

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

**FROM:**

**PLEASE SEND TO:**

\_\_\_\_\_  
 Name of Clinic/Organization/Physician

\_\_\_\_\_  
 Name of Person or Physician

\_\_\_\_\_  
 Address (Street/PO)

\_\_\_\_\_  
 Address (Street/PO)

\_\_\_\_\_  
 City, State, Zip

\_\_\_\_\_  
 City, State, Zip

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Information to be released:**

- All medical records
- Medical records for the dates ranging from: \_\_\_\_\_ to: \_\_\_\_\_
- Medical records relating to the following treatment/condition:

Billing statements dates \_\_\_\_\_

Other (e.g. X-rays, labs): \_\_\_\_\_

You **must** give us permission to release information regarding the following conditions by initialing each item (*Initial all that apply*):

\_\_\_\_\_ HIV/AIDS/STD related info

\_\_\_\_\_ Psychiatric disorders/mental health

\_\_\_\_\_ Drug and/or alcohol info

\_\_\_\_\_ Genetic testing info

Reason for the release:

- Personal
- Doctor
- Legal
- Insurance
- Other \_\_\_\_\_

**Patient Rights**

I understand that there may be a fee/charge for record retrieval and by signing this form I agree to pay all reasonable fees/charges associated. Should such records be sent directly to another physician for continuation of care there will be no charge. We are allowed 14 days to complete request, according to Washington State guidelines.

I may revoke this authorization in writing at any time. The only exception is when action has been taken in reliance on the authorization. This consent shall remain in effect for the period reasonable needed to complete the request.

\_\_\_\_\_  
 Patient or legally authorized individual signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed name if signed on behalf of the patient

\_\_\_\_\_  
 Relationship (parent, legal guardian, etc)

**What information was released** \_\_\_\_\_

Date: \_\_\_\_\_ Released by: \_\_\_\_\_