

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information:

\_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
(PRINT name of patient)

Information to be released from: Dedicated Women's Health Specialists  
1701 3<sup>rd</sup> ST SE Suite 200  
Puyallup, WA. 98372  
(253) 840-4444 FAX (253) 840-5239

Information to be release to:

\_\_\_\_\_  
Name of designated recipient  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City, State, Zip Code ( ) \_\_\_\_\_  
Phone number  
( ) \_\_\_\_\_  
Fax number

Information to be released:

- The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)
- All medical records
- Specific information (Please specify) \_\_\_\_\_

Purpose for which disclosure is being made: (Please check on of the following)

- Attorney
- Insurance
- Doctor
- Personal

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, Sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give Specific authorization for these records to be released.

\*\*EXCLUDE the following information from the records release (please initial)

- \_\_\_\_\_ Drug/Alcohol abuse/treatment & diagnosis
- \_\_\_\_\_ Sexually Transmitted Disease
- \_\_\_\_\_ HIV/AIDS diagnosis/treatment/testing
- \_\_\_\_\_ Mental illness or Psychiatric diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment.). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws,

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(Patient, Guardian\*, or Authorized Representative\*)

(Please provide documents to prove authority to sign on behalf of the patient)

This authorization will expire 90 days from the date signed.

Possible copying fee required.