AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information:

_____ DOB: _____ SS#: _____
(**PRINT** name of patient)

Information to be released from: _____
Name of designated recipient

_____
Address

_____ _(___)_____
City, State, Zip Code Phone Number

_(___)_____
Fax Number

Information to be sent to:

Dedicated Women's Health Specialist
1701 3rd ST SE Suite 200
Puyallup, WA 98372
(253) 840-4444 **FAX (253) 840-5239**

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 one 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 my specific authorization for these records to be released.

*** EXCLUDE the following information from the records released (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