WOMEN'S & FAMILY HEALTH SPECIALISTS

- Obstetrics
- Gynecology
- Family Medicine

1412 SW 43rd Street, Suite 200
Renton, Washington 98057
Telephone 425.271.4910
Fax 425.264.1041

Authorization to Release Protected Health Information

Please fill out form COMPLETELY to be sure that your MEDICAL RECORDS are not delayed.

Patient name: _____ Date of birth: _____

Previous name(s): _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

_____ All health care information in my medical record

_____ Health care information in my medical record relating to the following treatment or condition:

_____

_____ Health care information in my medical record for the date(s): _____

_____ Other (e.g., X-rays, bills), specify date(s): _____

You MAY NOT disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

____ Sexually transmitted diseases (includes AIDS/HIV) ____ Psychiatric disorders/mental health ____ Drug and/or alcohol use

Who will RECEIVE the health care information?

Name/Organization: _____

Address: _____

City: _____

State: _____ **Zip:** _____

Ph: _____ **Fax:** _____

Who will SEND the health care information?

Name/Organization: _____

Address: _____

City: _____

State: _____ **Zip:** _____

Ph: _____ **Fax:** _____

Reason(s) for this authorization (check all that apply): (Charges for copies of records may apply, see back for information)

_____ Continuing Care Doctor _____ Transfer of Care _____ Personal/Own Use _____ Insurance

_____ other (specify) _____

This authorization ends:

_____ on (date): _____ when the following event occurs: _____

_____ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Women's & Family Health Specialists based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the Medical Records Department Or
- Write a letter to Women's & Family Health Specialists.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____

Patient or legally authorized individual signature Date

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)