



Authorization for Release of Information

Patient name: _____ Date of birth: _____
Previous name: _____

I. My Authorization

Doctor's Name: _____

Address: _____

City, State, Zip: _____

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 use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

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

You may disclose this health care information to:

Name (or title) and organization: **WWMG Dept Of Family Medicine**
4301 Hoyt Ave Everett, WA 98203

Reason(s) for this authorization (check all that apply):

- at my request
- other (specify) _____
- check only if for marketing purposes
- check only if WWMG will be paid or get something of value for providing health information for marketing purposes

This authorization ends: *(This document does not permit disclosure of health information created more than 90 days after the date it is signed.)*

in 90 days from the date signed

on (date): _____

when the following event occurs: _____
(no longer than 90 days from date signed)

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship