Western Washington Medical Group

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: _____

Address: _____ City: _____ State:____ Zip: _____

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