Whitehorse Family Medicine
Western Washington Medical Group
875 Wesley St, Ste 250, Arlington, WA 98223
phone 360-435-2233 fax 360-435-3966

Authorization For Disclosure Of Health Information

1) I hereby authorize: _____

Address: _____

To disclose the following information from the health records of:

Patient Name: _____ Date of Birth: _____
Address: _____ Social Security #: _____
_____ Telephone: _____

Covering the Period(s) of Health Care

From (date): _____ To (date): _____
From (date): _____ To (date): _____

2) This information is to be sent to (name): _____

Address: _____

For the purpose of: _____

3) General information to be disclosed:

- o Complete Health Records
- o Consultation Reports
- o X-ray Reports
- o X-ray Films
- o Immunization Records
- o History & Physical Exam
- o Progress Notes
- o Laboratory Tests
- o Surgical Results
- o Other (Please Specify)

I understand that this will include information relating to (check and initial ONLY if information is to be sent):

- o Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV) Infection _____
- o Sexually Transmitted Diseases (STD) _____
- o Behavioral Health Service/Mental Health/Psychiatric Care _____
- o Treatment for Alcohol and/or Drug Abuse _____

4) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in 90 days.

5) Whitehorse Family Medicine, its employees and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

6) Please allow up to three weeks to receive your record. There may be a cost to copy your record. Please inquire at the front desk for further information.

7) Your records may be re-disclosed by the party that we are releasing them to, and therefore no longer protected by law.

SIGNED: _____ _____
Patient Date

_____ _____
Or Legal Representative (relationship to patient) Date