Authorization for Western Washington Medical Group / Marysville Family Medicine to RELEASE HEALTHCARE INFORMATION

Patient name: _____ **Date of Birth:** _____
Please print

Please release my healthcare information… (PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE)

From:
Name/Organization: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone number: _____

To:
Name/Organization: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone number: _____

REQUIRED: Please check ONE of the following:

_____ **ALL healthcare information (last 3 years)**

_____ **Specific CONDITION:** Healthcare information, including x-rays, and lab results, related to the **below-listed treatment or conditions**.

Specifically: _____

_____ **Specific DATES:** Healthcare information for the **below-listed date(s)**.

Specifically: _____

_____ Mutual exchange of information with Dr. _____ (expires 1 year from date of signing).

I also agree to the release of health care information regarding testing, diagnosis and/or treatment for:
(CHECK those you wish to EXCLUDE)

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

_____ Patient's initials

Purpose for which discloser/transfer of record is made:

___ Attorney ___ Insurance ___ Doctor ___ Personal (to patient) **service fee may apply*

This authorization expires in 90 days or until the following occurs: _____

I may cancel this authorization in writing as allowed by law. If I do not provide an expiration date or event, this authorization will expire in ninety (90) days of the date of authorization.
Once Marysville Family Medicine gives out the information, we have no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.
By signing this form, I acknowledge that I have read and agree to the terms articulated in this authorization form. I understand that I do not have to sign this authorization in order to receive healthcare benefits (treatment, payments or enrollment).

Patient Signature: _____ **Today's date:** _____

Parent/legally authorized patient representative: _____ **Today's date:** _____

Relationship to patient (if signed on behalf of patient): _____

OFFICE USE ONLY! ↓

Disposition of Request:
○ Faxed ○ Mailed ○ Picked Up Date: _____ Initials: _____.

WWMG /copy service.ROI updated 10-15