Western Washington Medical Group

Authorization for Western Washington Medical Group to RELEASE HEALTHCARE INFORMATION

Patient name:_____ **Date of Birth:** _____
Please print *mm / dd / yyyy*

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

From:
Western Washington Medical Group
1728 W. Marine View Dr., Suite 110
Everett, WA 98201

Which WWMG Clinic are you requesting records from?

_____

_____

Send Records To:
Name/Organization: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone number: (____) _____ - _____

Fax number: (____) _____ - _____

REQUIRED: I consent to release (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: ____/____/____ to ____/____/____

☐ Mutual exchange of information with provider: _____(expires 1 year from date of signing).

I do not consent to the release of health care information regarding testing, diagnosis and/or treatment for:
(CHECK those items you wish to EXCLUDE)

☐ HIV (AIDS virus) ☐ Sexually transmitted diseases ☐ Drug and/or alcohol use ☐ Other, please explain on the line below.

_____ **Patient initials**

Purpose for which discloser/transfer of record is made:

☐ Attorney ☐ Insurance ☐ Provider ☐ Personal (to patient) **service fee may apply*

This authorization expires in 1 year 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 one (1) year of the date of authorization. Once Western Washington Medical Group gives out the information, we have no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it. Patients thirteen (13) years of age and older must sign for behavioral health records for this form to be valid.

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:** _____
(Including Children 13yrs and older)
Parent/legally authorized patient representative: _____ **Today's date:** _____
(For patients 12yrs and younger)
Relationship to patient (if signed on behalf of patient): _____

>> For information on where to submit your form, visit wwmedgroup.com/medical-records-request and refer to the contact info on the chart. <<

OFFICE USE ONLY! ↓

Disposition of Request:

○ Faxed ○ Mailed ○ Emailed Date:_____ Initials:_____.