Western Washington Medical Group

Authorization for Release of Information

Patient name: ______________________________ Previous name: ______________________

Date of birth: ______________________ Phone number: ______________________________

My Authorization: I give my permission for the - *physician/entity/self* - listed below, to disclose my health care information consistent with this authorization: (*Getting information from*)

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 relation to the following treatment or condition: ______________

[ ] Health care information in my medical record for the date(s): ______________________________

[ ] Other (X rays, bills, etc..) specify date(s): ______________________________________

You may use or disclose health care information regarding testing, diagnosis, and treatment for the sensitive health information below (check all that apply). If none of the above boxes are checked, no information related to the testing, diagnosis or treatment of the categories below will be disclosed pursuant to this authorization. I understand that if I want to authorize your use of disclosure of this information later, I will be asked to sign another authorization.

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

You may disclose this health care information to: (*Giving information to*)

Name (or title) and organization: ____

Address: ______________________ City: ______________ State: __________ Zip: __________

Phone: ______________________________ Fax: ______________________________

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

[ ] at my request [ ] check only if for marketing purposes [ ] other (specify) ______________________

[ ] 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: ______________________

I understand that I may change my mind and decide to cancel my authorization to use and disclose my health care information at any time. I understand that if I choose to revoke my authorization, I need to do it in writing by sending a letter to the person or organization listed above. I also understand that if I cancel this authorization, the information may have already been used or disclosed before I changed my mind. I understand that I may refuse to sign this form, and that I do not need to sign it to receive treatment, for payment for health care services to be made, or to enroll or be eligible for benefits. However, if research related treatment is going to be provided, or if health care services are going to be provided solely for the purpose for providing health information to someone else and my signature on this authorization is necessary to make such disclosures, I will not receive those health care services if I refuse to sign this authorization.

I understand that if the person or organization who receives information pursuant to this authorization is not a health care provider or health plan covered by federal or state privacy laws, the information listed above could be re-disclosed by them and will no longer be protected by those regulations.

______________________________ ______________ ______________

Patient or legally authorized individual signature *Date* *Time*

______________________________ ______________________

Printed name if signed on behalf of the patient *Relationship*

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Office use only

Type of records released: [ ] office visit notes, [ ] X ray, [ ] imaging reports, [ ] operative report / Date requested: ______________ Date released: ______________

Method: [ ] faxed, [ ] mailed, [ ] hand carried / Records = Date to: __________ Date from: __________ / Date X rays requested: ______________