Western Washington Medical Group

Authorization for Release of Information

Patient Name: _____ Date of birth: _____

Previous Name: _____

My Authorization: I give my permission for the physician/entity listed below to disclose my health care information consistent with this 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 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 or disclosure of this information later, I will be asked to sign another authorization.

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

You may disclose this health care information to:

Name (or title) and organization: **Western Washington Medical Group – GI Department**
Address: **4225 Hoyt Ave, Ste A** City: **Everett** State: **WA** Zip: **98203**
Phone: **(425) 259-3122** Fax: **(425) 252-9860**

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

- ☐ At my request
- ☐ 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
- ☐ Other (specify) _____

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 for the date signed
- ☐ On (date): _____
- ☐ When the following event occurs: _____

(No longer than 90 days from date signed)

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 of 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 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 signed	Date	Time

Printed name if signed on behalf of the patient	Relationship

Note: there may be a charge for copying medical records, this service provided by an outside agency