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# AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

Address: _____ Day Phone: _____

_____ Email: _____

I request all medical records of the patient named above to be released from:

Everett Ear Nose & Throat
5929 Evergreen Way
#200
Everett, WA 98203

Reason for Release of Information:

Personal

other: _____

Send all medical records to:

☐ Me at same address as above **$25**

☐ My new healthcare provider below **$25**

Name: _____

Address: _____

_____

Email: _____

Fax : _____

This request and authorization applies to all my medical records. I understand my medical records may include information regarding mental health, psychotherapy notes, alcohol/drug use, Sexually Transmitted Disease results (whether positive or negative) and HIV treatment. I understand this authorization will be in effect for 12 months unless cancelled by me in writing and that my cancellation will take effect when Clary Document Management (Clary) receives my notice in writing submitted to the address above. I understand once Clary discloses my health information herein, it may no longer be protected by federal privacy laws.

**I understand should I will *pre-pay* a $25 fee to reproduce medical records.**

Patient Signature _____ Date_____

Patient Authorized Representative: _____ Date_____

Authority to Represent Patient: _____