Western Washington Medical Group
Everett Family Medicine

Authorization for Release of Information Form

Current Name:_____ DOB: _____

Previous Name _____

My Authorization: I give permission for the provider/entity listed below to disclose my health care information consistent with this authorization.

Providers Name: _____

Address: _____ City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

You may use or disclose the following care information (check all that apply):

() Last 3 yrs. of health care information in my medical record
() Health care information relating to the following condition: _____
() Health care information for the following date(s):_____
() Other (e.g., X-rays, billing), specify date(s): _____

The following health care information regarding testing, diagnosis, and treatment for the sensitive health information below <u>WILL BE INCLUDED</u> unless I want this information <u>to be EXCLUDED</u> and I HAVE checked the boxes below. Please initial after each checked box as well.

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

You may disclose this health care 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 (personal) () Transfer of Care () Continuing Care
() Disability () Insurance () Legal review

This Authorization ends:
(This document does not permit disclosure of information created more than 90 days after the date signed.)
() In 90 days from the date signed () On (date): _____
() When the following event occurs: _____

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY

I understand that I many 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, 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 of 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 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 provide 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*

_____ _____

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