Western Washington Medical Group
Whitehorse Family Medicine

Whitehorse Family Medicine
875 Wesley Street, Ste 250
Arlington, WA 98223
Phone: 360-435-2233
Fax: 360-435-3966

Authorization For The Release Of Medical Information

Patient Name: _____ Date of Birth: _____
Are medical records filed under another name?
_____ Phone: _____

INFORMATION TO BE RELEASED ***BY***:	INFORMATION TO BE RELEASED ***TO***:
☐ WWMG - Whitehorse Family Medicine 875 Wesley Street, Ste. 250 Arlington, WA 98223	☐ WWMG - Whitehorse Family Medicine 875 Wesley Street, Ste. 250 Arlington, WA 98223
☐ _____ Organization/Person Name	☐ _____ Organization/Person Name
Address:_____	Address:_____
_____	_____
Phone: Fax:	Phone: Fax:

Please disclose medical records for the purpose of: _____
Covering the period(s)
From (date): _____ To (date) _____

General information to be disclosed:

- ☐ Complete Health Records
- ☐ Consultation Reports
- ☐ X-ray Reports
- ☐ X-ray Films
- ☐ Immunization Records
- ☐ History & Physical Exam
- ☐ Progress Notes
- ☐ Laboratory Tests
- ☐ Surgical Results
- ☐ Other: _____

I understand that this will include information relating to: (check & initial **ONLY** if information is to be sent)

- ☐ Acquired Immunodeficiency Syndrome (AIDS) / Human Immunodeficiency Virus (HIV) Infection _____
- ☐ Sexually Transmitted Disease (STD) _____
- ☐ Behavioral Health Service / Mental Health / Psychiatric Care _____
- ☐ Treatment for Alcohol and/or Drug Abuse _____

- I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, **this authorization will expire in 90 days**.
- WWMG Whitehorse Family Medicine, its employees, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- Please allow up to three weeks to receive your record. There may be a cost to copy your record. Please inquire at the front desk for further information.
- Your records may be re-disclosed by the party that we are releasing them to, and therefore no longer protected by law.

Patient Signature: _____ Date: _____

Legal Representative: _____ Date: _____

Printed Name: _____ Relationship to patient:_____