Authorization for Western Washington Medical Group / Marysville Family Medicine to RELEASE HEALTHCARE INFORMATION

Patient name: ______________________________ **Date of Birth:** ____________________
Please print

Please release my healthcare information… (PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE)

From:
Name/Organization: ____________________
Address: ____________________
City: ____________________
State: ____________________ Zip: ________
Phone number: ____________________
Fax number: ____________________

To:
Name/Organization: ____________________
Address: ____________________
City: ____________________
State: ____________________ Zip: ________
Phone number: ____________________
Fax number: ____________________

REQUIRED: Please check ONE of the following:

________ **ALL healthcare information (last 3 years)**

________ **Specific CONDITION:** Healthcare information, including x-rays, and lab results, related to the **below-listed treatment or conditions**.

Specifically: ______________________________

________ **Specific DATES:** Healthcare information for the **below-listed date(s)**.

Specifically: ______________________________

________ Mutual exchange of information with Dr. ____________________ (expires 1 year from date of signing).

I also agree to the release of health care information regarding testing, diagnosis and/or treatment for:
(CHECK those you wish to EXCLUDE)

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

________ Patient's initials

Purpose for which discloser/transfer of record is made:

____ Attorney ____ Insurance ____ Doctor ____ Personal (to patient) **service fee may apply*

This authorization expires in 90 days or until the following occurs: ____________________

I may cancel this authorization in writing as allowed by law. If I do not provide an expiration date or event, this authorization will expire in ninety (90) days of the date of authorization.
Once Marysville Family Medicine gives out the information, we have no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.
By signing this form, I acknowledge that I have read and agree to the terms articulated in this authorization form. I understand that I do not have to sign this authorization in order to receive healthcare benefits (treatment, payments or enrollment).

Patient Signature: ______________________________ **Today's date:** ____________________

Parent/legally authorized patient representative: ______________________________ **Today's date:** __________

Relationship to patient (if signed on behalf of patient): ______________________________

OFFICE USE ONLY! ↓

Disposition of Request:
○ Faxed ○ Mailed ○ Picked Up Date: __________ Initials: __________.

WWMG /copy service.ROI updated 10-15

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