AUTHORIZATION FOR RELEASE OF INFORMATION

Patient information:

_____

(PRINT name of patient) DOB SS#

Information to be released from:

_____

Name of designated Facility or Provider

_____

Address

_____

City, State, Zip Phone Number

I request and authorize the facility or provider named above to release health care information of the patient named above to:

Salmon Bay Family Medicine, PLLC_____

Name of designated recipient

21701 76th Ave W, Ste 303____ _____

Address

Edmonds, WA 98026_____(206) 781-6300__

City, State, Zip Phone Number

Information to be released:

☐ The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)
☐ All medical records
☐ Specific Information (Please Specify):

Purpose for which disclosure is being made: (Please check one of the following)

☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal

Patient Authorization:
I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested diagnosed or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization my re-disclose it, at which time it may no longer be protected under Privacy laws.

_____

Signature of Patient's authorized representative Date signed

This Authorization will expire 90 days from the date signed