Authorization of Release of Information

ALL SECTIONS MUST BE FILLED OUT TO PROCESS REQUEST

SECTION A: I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

Please make sure to fill out address and/or fax number for both offices. By not filling out this information, the request may not be processed.

Patient Name: ______________________

Date of Birth: __________/__________/___________

Patient Previous Name: ______________________

Social Security Number:___________-________-___________

Person(s)/organization authorized to use/disclose information (**from**):

Organization/Doctor: **Evergreen Women's Health Center**

Address: **NE 130th Lane Ste 110**
Kirkland, Wa 98034

Phone Number: **(425) 285-0060**

Fax Number: **(425) 285-0070**

Person(s)/organization authorized to receive the information **(to)**:

Doctor:

Address:

Phone Number:

Fax Number:

Information that may be used/disclosed: (include dates where appropriate)

( ) Entire Medical Record
( ) Records of visits (specific)
( ) Discharge Summary
( ) Consultation Report(s)
( ) History & Physical
( ) Operative Report(s)
( ) Laboratory Reports (all)
( ) Ultrasounds, mammograms
( ) Progress Notes
( ) Statements of Charges/Payments
( ) OB Care
( ) Other

Important - I understand that the following can be omitted when disclosing healthcare information. *Please check the information you would like to* ***disclose.***

( ) HIV or AIDS Information
( ) Sexually Transmitted Diseases
( ) Drug and/or alcohol
( ) Psychiatric disorders/mental health

SECTION B: Reason for release of health care information

( ) Transferring Care
( ) Second Opinion
( ) Moving
( ) Attorney/Legal
( ) Insurance Claim
( ) Personal Use
( ) Disability Determination
( ) Other (Please specify) ______________________________________

SECTION C: *If this section is not filled out, your request will not be processed.*
I understand that I may revoke this authorization at any time by notifying Evergreen Women's Health Center in writing. I understand that the revocation will not apply to information that has already been released.

____
Signature of Patient

____
Today's Date

____
Printed Name