

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**): _____

Person(s)/organization authorized to receive the information (**to**): **Evergreen Women's Health Center**

Organization/Doctor: _____

Doctor: _____

Address: _____

Address: **NE 130th Lane Ste 110**

Kirkland, Wa 98034

Phone Number: _____

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

Fax Number: _____

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

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

Entire Medical Record

Laboratory Reports (all)

Records of visits (specific)

Ultrasounds, mammograms

Discharge Summary

Progress Notes

Consultation Report(s)

Statements of Charges/Payments

History & Physical

OB Care

Operative Report(s)

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