Authorization to release healthcare information

Patient's Name: ____

Date of Birth: ____________________ Previous Name: ______________________________

I request and authorize ______________________________ to release healthcare information of the patient named above to:

Name: ____

Address: ____

City, State, Zip Code: ____

Phone number: ____

Fax number: ____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates of treatment: ______________________________

☐ All healthcare information

☐ Other: ______________________________

The purpose of disclosure is: ☐ Change of Insurance or Physician ☐ Continuation of Care ☐ Referral ☐ Other:

I would like to receive my records via: ☐ Mail ☐Pick Up ☐ Phone Call

I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted disease, 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 healthcare information relating to such diagnosis, testing, and/or treatment. **I also understand that in order to comply with the new HIPAA laws, my records need to be reviewed for accuracy and completeness before they are released to anyone. This review process may take up to the full 15 working days allowed by Washington state law.**

____
Signature of patient or patient's authorized representative Date

____
Relationship of status if signed by anyone other than patient (parent, legal guardian, etc.)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED.