INFORMED CONSENT – MEDICAL RECORDS RELEASE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/PROTECTED HEALTH INFORMATION

Patient's Name:	**Date of Birth:**	**Social Security #:**
Address:		
I request and authorize *(Provide Physician Name/Facility Name)*:		
To release healthcare information of the patient named above to: (Provide Information below⮟) *(Provide the Physician Name, Facility Name, Recipient Name)*		
Name:		
Address:		
Phone:	Fax:	

This request and authorization applies to:	
☐ **Complete Medical Records (All healthcare information)**	☐ **Laboratory Reports/Pathology Reports**
☐ **Healthcare information relating to the following treatment, condition, or dates:**	☐ **Billing Statements**
☐ **Physician office/Clinical Records**	☐ **All hospital/Institution Records**(includes surgical reports, history/physical exam, consultation reports, discharge summary reports)
☐ **Other:**	

Definition: *Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.*

☐ Yes ☐ No	I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
☐ Yes ☐ No	I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I understand that providing my authorization is voluntary. I need not sign this Authorization for Release of Protected Health Information to continue to receive healthcare treatment. I understand that I may revoke this authorization in writing at any time except to the extent that disclosure was made prior to the time I revoked this authorization. I further understand that I may inspect and receive copies of the information to be disclosed. _____ Initial

I understand that the heath records and information disclosed, or some portion thereof, may be protected by the Federal Health Insurance Portability and Accountability Act ("HIPPA"). I further understand that it is possible that the information described above may be re-disclosed by the recipient and may no longer be protected by HIPPA. I understand that my records may be protected under state law and, if so, cannot be disclosed without my written consent unless otherwise provided for in the law and/or regulations. _____ Initial

This Authorization for Release of Protected Health Information shall expire one (1) year from the date below. My signature acknowledges that I have read, understand, and authorize the release of the information described above.

Patient Signature:		Date Signed: