OVERLAKE MEDICAL CLINICS

1035 116TH AVENUE NE
BELLEVUE, WA 98004
HIM ROI FAX NUMBER: 425-233-6286

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

I, _____, hereby authorize _____
to disclose health care information in the medical records of:

_____ Birth Date: _____
PRINT NAME OF PATIENT

INFORMATION TO BE ❑ SENT TO: ❑ SENT FROM:

_____
NAME OF DESIGNATED RECIPIENT

_____
ADDRESS

_____
CITY, STATE, ZIP CODE PHONE NUMBER

WHAT KIND OF INFORMATION DO YOU WANT DISCLOSED? (CHECK ONE BOX)

❑ Information from the most recent one year of visits. ❑ Information from Date: _____ to Date: _____.

SPECIFIC INFORMATION. PLEASE CHECK BOX:

❑ Progress Notes ❑ EKGs ❑ Immunizations
❑ Lab Reports ❑ Problem Lists ❑ Consultations
❑ Radiology Reports ❑ Medication List ❑ Accounting of Disclosure
❑ Other (Please specify): _____

PURPOSE FOR WHICH DISCLOSURE IS BEING MADE:

❑ Attorney ❑ Insurance ❑ Doctor ❑ Personal

PATIENT AUTHORIZATION:

You are authorized to release copies of my medical records. I understand that my records are privileged and confidential and I waive this status. I authorize release of all medical information, including psychiatric, drug and/or alcohol abuse records, the testing, counseling or treatment of AIDS, HIV or any sexually transmitted diseases and other confidential information. I understand I may be charged unless the records are being sent to another health care provider for the purpose of continuing care.

***EXCLUDE the following information from the records released (please initial):**

_____ Drug/Alcohol abuse/treatment & diagnosis _____ Sexually transmitted disease
_____ HIV/AIDS diagnosis/treatment/testing _____ Mental illness or Psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study, or
- To resolve health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. To view the process of revoking this authorization, please read the Privacy Notice to our patients. I understand that once Overlake Medical Clinics discloses health information, the person or organization that receives it may re-disclose, at which time it may no longer be protected under Privacy laws.

DATE SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PARTY* RELATION TO PATIENT

(*Please provide documents to prove authority to sign on behalf of the patient)

If you desire a copy of this authorization, please notify a representative of the Medical Records department upon completion of this form. Authorization valid for only 90 days from signing this request. To be valid this form must be signed and dated.