Issaquah Obstetrics & Gynecology, PLLC

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Authorization for the Disclosure of My Health Care Information

Please allow 7-10 business days for release of health care information

Patient Name_____ Date of Birth _____

Previous Name (s) _____ SS # _____

Address _____ Phone # _____

Information to be released by:

Name _____

Organization _____

Address_____

_____

Phone # _____

Information to be released to:

Name _____

Organization _____

Address _____

_____

Phone # _____

Authorization
You may disclose the following health care information (check one):

- □ All health care information in my medical record for the last 2 years
- □ All health care information in my record
- □ Other specific information (lab reports, medical imaging etc) _____

Reason for authorization:

□ Transferring care □ Other _____

I understand that unless revoked this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with the document. Unless specifically included by you, this authorization excludes the release of specifically protected information requiring my explicit authorization. This includes referral, diagnosis and treatment information related to:

- □ Substance abuse
- □ Sexually transmitted diseases
- □ Mental Health Conditions/Psychotherapy
- □ HIV/AIDS

I understand that my health care information is protected by state and federal regulations that protect the confidentially of this information and that my health care information may not be released or disclosed without my written authorization, unless otherwise provided by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.

I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization at the time of signing.

I understand that if I request records for personal use to hand-carry to another health provider or for parties uninvolved in my health care, there may be a charge. Non-emergent release of records may take up to 10 working days. Emergency requests are given priority processing. Emergency status applies only to release of records directly to another health care provider for urgent patient care. There is no charge to release records to another health care provider.

MINORS: A minor patient's signature is required to release the following information: (1) conditions relating to the minor's reproductive care including but not limited to contraception, pregnancy and pregnancy termination, sterilization and sexually transmitted diseases (age 14 and older) (2) alcohol and/or drug abuse (age 13 and older) and (3) mental health conditions (age 13 and older).

Patient's Signature _____ Date _____

Representative/Guardian Signature _____ Date _____