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|   | South Sound Pulmonary & Sleep Medicine, PLLC\_\_\_500 Lilly Rd NE, Suite 201, Olympia, WA 98506 •360.413.8272 • Fax 360.413.8878 |

## Authorization to Release Medical Information

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Last First MI Mo/ Day/Year

Previous Name (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize information be released from: Please send my records to:**

**South Sound Pulmonary & Sleep medicine, PLLC**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Physician/facility to release information Physician/facility to receive information

500 LILLY ROAD NE SUITE 201

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Address

OLYMPIA, WA 98503

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip City, State, Zip

(360) 413-8878

(360) 413-8272

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Phone/Fax numbers Phone/Fax numbers (please mail if over 15 pages)

## Type of Information to be Released

* **General Medical Records –** Excluding protected records. Copies of medical records will be limited to two (2) years of information including lab and x-ray reports unless otherwise requested. Outside records will not be copied. Please contact the facility directly for this service.
* **Specific Information Only:**
* Health care information related to the following treatment/condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Health care information for the date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Protected or sensitive information:** I understand that certain information cannot be released without specific authorization as required by State/Federal law. **BY INITIALING** I authorize the release of the following information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drug and/or alcohol use \_\_\_\_\_\_\_\_\_\_\_\_\_\_ HIV (AIDS virus)

INITIAL INITIAL

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sexually transmitted diseases \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mental Health Treatment

INITIAL INITIAL

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 to take part in a research study or to receive health care when the purpose is create health care information for a third party. I may revoke this authorization in writing. If I did, it would not effect any actions already taken by the facility or individual based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are to fill out a revocation form or to write a letter to the practice or facility. Once health care information is disclosed, the person/ organization that receives it may re-disclose it. Privacy laws may no longer protect it.

**This authorization ends in 90 days or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (insert applicable date or event not longer than 90 days from date signed.)

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Patient or legally authorized individual signature Relationship to patient Date