Authorization For Release of Medical Records to PNW Family Medicine

AUTHORIZATION TO DISCLOSE RECORDS OF:

NAME LAST	FIRST	MIDDLE	DATE OF BIRTH

FORMER NAMES (IF APPLICABLE)

DISCLOSE TO:

PNW Family Medicine 1310 116th Avenue, Suite B Bellevue, WA 98004	Phone: (425) 285-6900	Fax: (833) 464-3005

AUTHORIZATON:

SOURCES: I authorize the following organization to disclose or give access to confidential information about me as described below. Information may be provided verbally or by computer data transfer, mail, fax, or hand delivery.

Organization: Overlake Family Medicine
3080 148th Ave SE, Suite 115
Bellevue, WA 98007

RECORDS: I authorize the following records to be disclosed:

- ☐ All client records, AKA Complete Chart with Addenda or Legal Medical Summary OR
- ☐ The following records only (please list):

PLEASE NOTE: If your client or other confidential records include any of the following information, you must also complete the below section to allow disclosure of these records.

SPECIAL RECORDS: I give my permission to disclose the following information held in records (check all that apply – we recommend checking all so your medical record is complete):

- ☐ HIV/AIDS and STD test results, diagnosis, or treatment records (RCW 70.02.220)
- ☐ Mental health records (RCW 70.02.230 or 240)
- ☐ Substance Use Disorder records (42 CFR Part 2)

- This permission is valid for 180 days or ☐ until _____ (date or event, if not checked, will be 180 days).
- I may revoke or withdraw my permission in writing at any time, but that will not affect information already produced.
- I understand that my records may no longer be protected under the laws that apply to organization after they are produced.
- A copy of this form is valid to give my permission to disclose records.

AUTHORIZED BY (SIGNATURE)	DATE SIGNED	TELEPHONE NUMBER (AREA CODE)

PRINT NAME	WITNESS/NOTARY (SIGN AND PRINT NAME, IF APPLICABLE)

If I am not the person who is the subject of the records, I am authorized to sign because I am the:
☐ Parent of minor ☐ Legal Guardian ☐ Personal Representative ☐ Other: _____

Notice to those receiving information: If these records contain information about HIV, STDs, or alcohol or drug abuse, you may not further disclose that information under federal and state law without specific permission of the subject and meeting specific legal requirements.