AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I,_____, hereby authorize_____ to disclose health care

information in the medical records of _____.
(Print name of patient)

Birthdate: _____

INFORMATION TO BE SENT TO:

NAME: _____
ADDRESS:_____
CITY/STATE/ZIP: _____
PHONE: _____
FAX:_____

INFORMATION TO BE SENT FROM:

NAME:_____
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE: _____
FAX: _____

HIM ROI FAX NUMBER: 425-233-6286

INFORMATION TO BE RELEASED:

- ☐ The most recent 2 years of medical information
- ☐ All medical records
- ☐ Other (please specify): _____

INFORMATION TO BE EXCLUDED:

- ☐ Drug/alcohol abuse/treatment & diagnosis
- ☐ Sexually transmitted diseases
- ☐ HIV/AIDS treatment/testing
- ☐ Mental illness or psychiatric diagnosis/treatment

PURPOSE FOR WHICH DISCLOSURE IS BEING MADE:

☐ Doctor ☐ Attorney ☐ Personal ☐ Insurance

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.

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 authorized 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 receive 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) STAFF INITIAL_____

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