AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information:

_____ **BD:** _____ **SS#:** _____
(PRINT Name)

Information to be released from: _____
(Name of Designated Facility or Provider)

Provide and disclose to: Attorney at Law
ADDRESS
CITY/STATE/ZIP

The purpose for this release of patient health information is: Legal Representation/Attorney

____ Check here to allow provider to fax patient information to attorney's fax as follows (if requested): _____

NOTE: *We have a dedicated fax line, number above, for privacy purposes. However, it is possible a provider could dial a wrong number in attempting to fax the requested documents. In such event, most fax cover sheets indicate that the information contained therein is confidential and, if the document was received in error, the documents should be destroyed and the sender notified.*

____*(Initials)* I have read the above note and agree medical records may be faxed (if requested), to my attorney.

Information to be released:

1. GENERAL RELEASE:
This request shall allow the release of any and all records in your possession for the following period(s):

_____All medical records (unlimited in time)
_____The most recent ___ years of information
_____Specific information (specify): _____

"Records information" as used herein shall refer to all of the following:

D All Medical Records (including protected records identified below)
a Discharge Summary(ies)
o Operative/Procedure Report(s)
D History and Physical
D Progress Notes
□ Physical Therapy Notes
D Records from Other Providers/Facilities
D Other Reports (specify) _____

o EKG's
D X-rays/CT scans/MRI's (diagnostic imaging)
D Laboratory Results/Pathology Reports
o Consultation Report(s)
D Emergency Room Record(s)
n Nurse's Notes
a Any and all billing information
a Any and all insurance information
o Records of other health care providers in your possession

2. INFORMATION PROTECTED BY STATE/FEDERAL LAW:
This consent shall/will include disclosure of the following protected records UNLESS I have initialed below.

____ Chemical Dependency Diagnosis/Treatment
------- Mental Health Diagnosis/Treatment (includes Psychiatric and psychological evaluation)
___ Drag/Alcoholism Diagnosis/Treatment
___ Sexually Transmitted Disease Diagnosis/ Treatment (includes AIDS/HIV testing)

I UNDERSTAND:

1. That this authorization for disclosure is intended to comply with both the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and/or Washington's Uniform Health Care Act, RCW 42.17, Chapter 70, and is intended to comply with the same and to allow my attorney with unfettered access to my medical records and bills and/or to obtain reports and/or schedule meetings with my health care providers, if they desire.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. This authorization expires in ninety (90) days from the date of signing, and/or from the typed date appearing below.

4. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

5. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

6. A copy of this authorization shall have the same force and effect as the signed original.

Signature of Patient or Legal Representative Date

AUTHORITY TO SIGN:

[ ] Patient:_____

[ ] Patient's parent: _____

[ ] Other:_____