Authorization to Release or Disclose Healthcare Information

Patient/Maiden Name: _____ Birthdate: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

INFORMATION TO BE RELEASED FROM (SELECT ONLY ONE):

☐ Sound Family Medicine ☐ Name (or title) of Organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

INFORMATION TO BE RELEASED TO (SELECT ONLY ONE):

☐ Sound Family Medicine ☐ Name (or title) of Organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

THE FOLLOWING COMMUNICATION OR RECORDS ARE REQUESTED:

☐ All records dating back 2 years (preferred when requesting for SFM providers) ☐ All healthcare information

☐ Only healthcare information relating to the following treatment, or date(s) of treatment: _____

_____

PROTECTED INFORMATION (CHECK THE ITEMS TO BE EXCLUDED FROM MEDICAL RELEASE):

☐ Sexually transmitted disease (including HIV/AIDS) ☐ Psychiatric (Mental Health)

☐ Reproductive care (including contraceptive and pregnancy related services) ☐ Substance Abuse

PURPOSE OF RELEASE:

☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal ☐ Transfer of Care

☐ Verbal or phone communication only (no records at this time) ☐ Other: _____

THIS AUTHORIZATION EXPIRES 90 DAYS FROM THE DATE SIGNED UNLESS SPECIFIED BELOW:

☐ Date: _____ **OR** ☐ Event (death, age, etc.): _____

DELIVERY METHOD (FOR PERSONAL RECORD REQUESTS):

Record on (choose ONE): ☐ Disk ☐ Paper

☐ Mail to Address above **OR**

☐ Pickup at SFM location (choose ONE): ☐ 10th Street ☐ 31st Avenue ☐ Bonney Lake ☐ Sunrise

MY RIGHTS/AUTHORIZATION

I understand that I'm not required to sign this authorization in order to receive healthcare services and benefits. By signing this form, I acknowledge that all information provided is accurate. I understand that to revoke this authorization I must submit a written request to Sound Family Medicine. Any records released before a revocation request is processed would not apply. I also understand that once healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws no longer protect it. I understand I may be responsible for any copy service fees that may apply.

Patient or Legally Responsible Party: _____ Date _____

Printed Name (if not signed by patient): _____ Relationship to Patient _____

Minor's Signature* (between age 13 and 17): _____ Date _____

* A minor's signature is required to disclose information related to reproductive care (at any age), sexually transmitted diseases (14 yrs and older), HIV/AIDS (14 yrs and older), drug and/or alcohol abuse (13 yrs and older), and mental health or illness (13 yrs and older). Any release signed by a minor expires upon age of maturity (18 years) unless specified sooner.

INTERNAL USE ONLY: Please complete below and return to medical records

Request received by (print full name): _____ WSDL/ID# _____

Verified by (employee first and last name): _____ Date _____

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