Patient Name: _____ **Date of Birth**: ____/____/____

Previous Name (If Applicable): _____ **Phone:** _____

Mailing Address: _____

I hereby request and authorize the following release of information:

Information to be released **TO:**
Providence Medical Group
Phone: 360-493-4276
Fax: 360-570-3339
Clinic: _____

Information to be released **FROM:**
Phone:_____
Fax: _____
Organization Name:
_____

Information to be released:

☐ All Medical Records ☐ Date(s) or Date Range ☐ Billing Information

☐ My health information relating the following condition or treatment _____

☐ Last **TWO** years of H&P; ALL labs/imaging/pathology/immunizations

☐ Other _____

INCLUDE the following information from my records released

I understand that my records may contain information regarding the following sensitive diagnosis or treatment.

If the item is initialed, then I give my specific authorization for these records to be released.

PLEASE INITIAL:

____ Drug/Alcohol abuse diagnosis/treatment
____ HIV/AIDS testing/diagnosis/treatment
____ Sexually Transmitted Diseases
____ Mental Illness/Psychiatric diagnosis/treatment

PURPOSE FOR DISCLOSURE:

☐Patient's Request ☐Continuing Care ☐Legal ☐Insurance ☐Transfer of Care

☐Other (explain): _____

This Release expires on the following date or when the following event occurs:

Date: ____/____/____ OR Event: **180 days after signing**

MY RIGHTS

I understand that 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 form in order to take part in a research study OR to receive heath care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Providence based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

To revoke your authorization, write a letter to:
Providence Medical Group - Medical Records
1018 Capitol Way S Suite 301
Olympia WA 98501

Once Providence discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Signature: _____ **Date:** _____/_____/_

***If signature is of a personal representative of the patient, please complete the following**

Personal representative's name: _____ Relationship to patient: ☐Parent ☐Legal Guardian* ☐Power of Attorney for Healthcare* ☐Other*: _____

Attach legal documentation if you are a personal representative other than parent

For Official Use Only
Release of Information completed by:
Name: _____
Clinic: _____
Date: _____/_____/_____

PROVIDENCE Health & Services

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Identification:

Align Patient ID Here