

# AUTHORIZATION TO RELEASE PATIENT INFORMATION

## PATIENT IDENTIFICATION

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

SS# \_\_\_\_\_ Other Last Names Used \_\_\_\_\_

- This authorization may be revoked in writing at any time except to the extent already relied upon, and will expire in 90 days unless previously revoked.
- You may inspect or receive a copy of the information being released.
- The information used or disclosed may be released by the recipient and no longer protected by the Federal privacy Rule
- You may refuse to sign this authorization to release information and this will not affect your access to care.

## INFORMATION TO BE RELEASED FROM:

I hereby authorize the following organization to release the medical information stated below from the patient's medical record:

- Meridian Women's Health **or**
- \_\_\_\_\_ (Organization/Person)  
\_\_\_\_\_ (Street Address)  
\_\_\_\_\_ (City, State, Zip)  
\_\_\_\_\_ (Telephone / Fax #)

## INFORMATION TO BE RELEASED TO:

- \_\_\_\_\_ (Organization/Person)  
\_\_\_\_\_ (Street Address)  
\_\_\_\_\_ (City, State, Zip)  
\_\_\_\_\_ (Telephone / Fax #)
- Meridian Women's Health 10330 Meridian Ave. N. #200, Seattle, WA 98133  
Phone: (206) 368-6644, Fax: (206) 368-6645

Purpose or reason for release of information

Requested by patient OR:

(specify) \_\_\_\_\_

| TYPE OF INFORMATION  | SPECIFIC RELEASE - REQUIRED  |
|--|--|
| <p>(Check appropriate box):</p> <p><input type="checkbox"/> Most Recent 3 year history</p> <p><input type="checkbox"/> Any and all records</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Other _____</p> | <p><b>Please initial</b></p> <p><b>This release</b> [ ] MAY [ ] MAY NOT</p> <p>Include specific information related to testing diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.</p> |

\_\_\_\_\_  
Signature of Patient (or other responsible person)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship (if not patient)

\_\_\_\_\_  
Signature of Witness