

Permission to Release Medical Records

I hereby authorize

Name: _____
 (Medical Provider holding records)

Address: _____

to disclose the following information from the health records of:

Patient Name:	Date of Birth:	SSN:	
	Covering the period(s) of health care	From	To

Information to be disclosed:

- | | |
|---------------------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> Complete health record(s) | <input type="checkbox"/> Progress notes |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Laboratory tests |
| <input type="checkbox"/> History & physical examination | <input type="checkbox"/> X-ray reports |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Photographs, videotapes, digital or other images |
| <input type="checkbox"/> Other (please specify) _____ | |

Optional:

<p>I specifically consent to disclosure of health care information that is protected by Federal and State Law regarding testing, diagnosis and treat for:</p> <p>(Check all that apply and sign):</p> <table border="0"> <tr> <td><input type="checkbox"/> Behavioral health services/psychiatric care</td> <td>Signature _____</td> <td>Date _____</td> </tr> <tr> <td><input type="checkbox"/> Treatment for alcohol and/or drug abuse</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Sexually transmitted diseases or HIV/AIDS</td> <td>_____</td> <td>_____</td> </tr> </table>			<input type="checkbox"/> Behavioral health services/psychiatric care	Signature _____	Date _____	<input type="checkbox"/> Treatment for alcohol and/or drug abuse	_____	_____	<input type="checkbox"/> Sexually transmitted diseases or HIV/AIDS	_____	_____
<input type="checkbox"/> Behavioral health services/psychiatric care	Signature _____	Date _____									
<input type="checkbox"/> Treatment for alcohol and/or drug abuse	_____	_____									
<input type="checkbox"/> Sexually transmitted diseases or HIV/AIDS	_____	_____									

This information is to be disclosed to:

<p>Russell W. Faria, DO, PC 15215 SE 272nd Street, Suite 103 Kent, WA 98042</p>	<p>Phone: (253) 639-1883 Fax: (253) 639-1891</p>
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Reason(s) for this Authorization (Check all that apply):

- | | | |
|-------------------------------------------|------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Transfer of Care | <input type="checkbox"/> Diagnostic Evaluation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Follow-up Care | <input type="checkbox"/> Legal/Life Insurance | |

This authorization shall be in force and effect until :

- 180 days from the date signed
- on (date): _____
- when the following event occurs: _____
 at which time this authorization to use or disclose this protected health information expires.

I do do not specifically consent to transmission of my medical records via facsimile (FAX) machine

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I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **the Medical Provider holding records** . I understand that a revocation is not effective to the extent that **the Medical Provider holding records** has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

◆.....◆

Signed: _____
 (Patient or (Legal Representative)

 (Date)