



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's name: _____ Previous Name: _____

Date of birth: _____ SS# _____ - _____ - _____

Phone number: _____

I request and authorize _____

To release health care information of the patient named above to :

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition, or dates of treatment: _____

_____ ALL health care information

_____ All Films/ X-rays/ MRIs

Other: _____

I understand that my express consent is required to release any health care information relation to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and or alcohol use. IF you have been tested, diagnosed for treated for HIV (AIDS virus, sexually transmitted disease, psychiatric distorts/mental health, or drug/alcohol use, you are specifically authorized to release all health care information relation to such diagnosis, testing or treatment.

Signature of patient or patient's
Authorized representative

Date signed

For Office Use Only:

DATE: _____ INITIALS: _____

MAILED – FAXED – PICKED UP

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