

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_ to disclose health care information in the medical records of \_\_\_\_\_  
(Print name of patient)

Birthdate: \_\_\_\_\_

**INFORMATION TO BE SENT TO:**

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY/STATE/ZIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
FAX: \_\_\_\_\_

**INFORMATION TO BE SENT FROM:**

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY/STATE/ZIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_  
FAX: \_\_\_\_\_

**HIM ROI FAX NUMBER: 425-233-6286**

**INFORMATION TO BE RELEASED:**

- The most recent 2 years of medical information
- All medical records
- Other (please specify): \_\_\_\_\_

**INFORMATION TO BE EXCLUDED:**

- Drug/alcohol abuse/treatment & diagnosis
- Sexually transmitted diseases
- HIV/AIDS treatment/testing
- Mental illness or psychiatric diagnosis/treatment

**PURPOSE FOR WHICH DISCLOSURE IS BEING MADE:**

- Doctor
- Attorney
- Personal
- Insurance

**PATIENT AUTHORIZATION:**

You are authorized to release copies of my medical records. I understand that my records are privileged and confidential and I waive this status. I authorize release of all medical information, including psychiatric, drug and/or alcohol abuse records, the testing, counseling or treatment of AIDS, HIV or any sexually transmitted diseases and other confidential information. I understand I may be charged unless the records are being sent to another health care provider for the purpose of continuing care.

**MY RIGHTS:**

I understand 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 authorized form:

- To take part in a research study, or
- To resolve health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. To view the process of revoking this authorization, please read the Privacy Notice to our patients. I understand that once Overlake Medical Clinics discloses health information, the person or organization that receive it may re-disclose, at which time it may no longer be protected under Privacy Laws.

\_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
**DATE**      **SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PARTY\***      **RELATION TO PATIENT**

(\*PLEASE PROVIDE DOCUMENTS TO PROVE AUTHORITY TO SIGN ON BEHALF OF THE PATIENT)      STAFF INITIAL \_\_\_\_\_

If you desire a copy of this authorization, please notify a representative of the Medical Records department upon completion of this form. Authorization is valid only 90 days from signing this request. To be valid, form must be signed and dated.



**HIM Release of Information Authorization**



\* 7 0 0 4 \*