ANKLE & FOOT CLINIC'S NORTHWEST

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Please read all information and instructions before completing and signing the authorization form.

Patient's Name_____ Birth Date_____
(PLEASE PRINT) LAST FIRST MI

Are medical records filed under another name? _____ Phone Number_____

INFORMATION TO BE RELEASED *BY:*	INFORMATION TO BE RELEASED *TO:*
REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER	**REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER**
Organization/ Person Name	Organization/ Person Name
Street Address City State Zip	Street Address City State Zip
Phone Fax	Phone Fax

TYPE OF MEDICAL INFORMATION REQUESTED:

- ☐ Complete medical record abstract (includes 3 years of chart notes, most recent labs/pathology & diagnostic imaging reports)
- ☐ Chart Notes only
- ☐ Lab Reports Only
- ☐ X-rays Only
- ☐ X-ray Reports Only
- ☐ Imaging (MRI/ CT / BONE SCAN)
- ☐ My health information only for the following treatment/ surgery_____
- ☐ My health information only for the following date(s)_____

REASON FOR REQUEST: Personal ___ Transfer of Care ___ Disability___ Insurance___ Workers Compensation ___ School ___ Second Opinion ___

Other (please explain):_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired Immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby *specifically authorized to release all information* or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded here:_____

I hereby consent to the release of the specified information relating to the diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.

This authorization expires_____ (date or event). Authorization will expire in 90 days if not otherwise specified.

Patient Signature_____ Date_____

Parent or Legal Guardian_____ Date_____

Relationship to patient, if other than patient_____
(You may be required to provide legal documentation as proof for power of attorney or guardianship)

Federal and state laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains. A general release is NOT sufficient. 42CFR Part 2: RCW 70.02.300