sound family medicine

AUTHORIZATION TO RELEASE OR DISCLOSE HEALTHCARE INFORMATION

Patient/Maiden Name: _____ Birthdate:____/____/____ Phone: _____
Address:_____ City: _____ State: _____ Zip: _____

INFORMATION TO BE RELEASED FROM: (SELECT ONLY ONE)

__Sound Family Medicine
__Organization/ Person Name: _____
Address: _____City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

INFORMATION TO BE RELEASED TO: (SELECT ONLY ONE)

__Sound Family Medicine
__Organization/ Person Name: _____
Address: _____City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

THE FOLLOWING COMMUNICATION OR RECORDS ARE REQUESTED:

__ All records dating back 2 years (preferred when requesting for SFM providers) __ All healthcare information
__ Only healthcare information relating to the following treatment, or date(s) of treatment: _____
_____

PROTECTED INFORMATION – CHECK THE ITEM(S) THAT YOU WANT EXCLUDED FROM THE RECORDS TO BE RELEASED:

__ Sexually transmitted disease (including HIV/AIDS) __ Psychiatric/mental health __ Substance abuse
__ Reproductive care (including contraceptive and pregnancy related services)

PURPOSE OF RELEASE:

__ Attorney __ Insurance __ Doctor __ Personal __ Transfer of Care
__ Verbal or phone communication only (no records at this time) __ Other: _____

THIS AUTHORIZATION EXPIRES 90 DAYS FROM THE DATE SIGNED UNLESS SPECIFIED BELOW:

On (date): _____ **OR** Event (death, age, etc.): _____

DELIVERY METHOD: (FOR PERSONAL RECORD REQUESTS)

Records on (ONE): __Disk __Paper
__ Mail to address above **OR** __ Pick up at (One): __10th Street __31st Ave __Bonney Lake __Sunrise

MY RIGHTS/AUTHORIZATION

I understand that I'm not required to sign this authorization in order to receive healthcare services and benefits. By signing this form, I acknowledge that all information provided is accurate. I understand that to revoke this authorization I must submit a written request to Sound Family Medicine. Any records released before a revocation request is processed would not apply. I also understand that once healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws no longer protect it. I understand I may be responsible for any copy service fees that may apply.

Patient or Legally Responsible Party Date

Printed Name (if not signed by patient) Relationship to Patient

Minor's Signature* (between age 13 – 17) Date

**A minor's signature is required to disclose information related to reproductive care (at any age), sexually transmitted diseases (14yrs and older), HIV/AIDS (14yrs and older), drug and/or alcohol abuse (13yrs and older), and mental health or illness (13yrs and older). Any release signed by a minor expires upon age of maturity (18 years) unless specified sooner.*

INTERNAL USE ONLY – PLEASE COMPLETE BELOW AND RETURN TO MEDICAL RECORDS

Records picked up by (print full name): _____ WSDL/ID#:_____

Verified by (employee first and last name): _____ Date: _____