WASHINGTON GASTROENTEROLOGY

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name ____
Last First Middle Maiden

Address ____
Street Apt. # City State Zip

Phone ____________________ Date of Birth ____________________

By signing this authorization, I authorize the use or disclosure of my health information.

I AM REQUESTING THIS INFORMATION FOR:

- ❑ Personal use
- ❑ Legal Use
- ❑ Transferring care
- ❑ Insurance
- ❑ Dissatisfaction with care
- ❑ Continuing care
- Reason ____________________
- ❑ Appealing the denial of federal Supplemental Security Income or Social Security Disability Benefits

NOTE: A charge may be incurred for copies being provided for legal, insurance, personal use, and in some instances the "other" category.

Once Protected Health Information is released by Washington Gastroenterology, it cannot be guaranteed that the recipient will not disclose the information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of health information. I understand that I do not have to sign this form to receive healthcare benefits.

Please Check One

❑ Healthcare information relating to the following treatment(s), condition(s) or dates of treatment(s) ____________________

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❑ Last two years of pertinent health information only (i.e. consults, labs, x-rays, etc.) ____________________

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Please Check One

Your facility ❑ ***is*** / ❑ ***is not*** authorized to release any healthcare information relating to such diagnosis, testing, or treatment relating to the: **testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or treatment of drug and/or alcohol abuse.**

NOTE: In compliance with Washington State law, minors must sign the request themselves if information requested includes: a) treatment for alcohol and/or drug abuse (13 and older), b) mental health conditions or c) conditions related to the minor's reproductive care and sexual history to include contraception, pregnancy, pregnancy termination, sterilization, and STDs (14 and older).

Health care information to be disclosed from	Health care information to be disclosed to
Person/Organization/Facility ____________	Person/Organization/Facility ____________
Address ____________	Address ____________
City/State/Zip ____________	City/State/Zip ____________
Fax ____________	Fax ____________
Phone ____________	Phone ____________

I release Washington Gastroenterology and its staff from all legal responsibility or liability that may arise from the release of information. I understand that I may revoke this consent in writing at any time, except when action has already been taken.

Patient Signature ______________________________ Date ____________________

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Relationship or status if signed by anyone other than the patient (i.e. parent, legal guardian, personal representative, etc.) Date

THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM DATE OF SIGNATURE OR UNTIL THE FOLLOWING EVENT OCCURS: ____________________