## KITSAP OBGYN, PLLC

Jorge O Zapata, MD Anita Alvestad-McIntyre, MD Nancy J Bohannon, MD Jennifer C Quimby, MD Kathy J Hebard, MD Amity A Marriott, MD Lori Nelson, ARNP

9750 Levin Rd, Silverdale, WA 98383 Tel: 360-307-7202 Fax: 360-698-6600

## Authorization to Request Information

atient Name:		Date of Birth:	
revious Name:		Telephone:	
. My Authorization			
You may obtain and use the follo	wing health card	e information (check all that apply):	
☐ The most recent records from	the last (2) years	s Health information from	
Specific health information:			
YOU MAY REQUEST HEALTH	CARE INFORM	ATION FROM:	
Name (or title) and Organization:			
Address:	Cit	ty:State:Zip:	
Telephone Number:		Fax:	
Reason(s) for this authorization (	check all that a	pply):	
At my request Transfe	-		
	img wedicar ce	in other (speeny).	
My Rights			
		nay contain information regarding the diagnosis and tre	
		r alcohol abuse, mental illness or psychiatric treatment. se the office and its staff from all legal responsibility of	
•		evoke this consent, except when the action has been tal	•
Please check here if you <u>DO NOT</u> w	ant any of the abov	ve-mentioned information released. (Checking this l	box may limit t
amount of records that will be sent.) $**$	Please specify the	information you DO NOT want released:	
<u>DISCLOSURE</u> : I understand I do not have enrollment).	to sign this authoris	zation in order to get health care benefits (treatment, pa	nyment or
		writing a letter to my Health Care Provider at Kitsap C	
		OBGYN, PLLC based upon this authorization. I may e. Once health care information is disclosed, the person	
that receives it may re-disclose it. Privacy			i or organization
EXPIRATION: This authorization expires	90 days after date s	igned.	
Patient or legally authorized individual signal	ture	Date	
Drinted name if signed on the hehalf of the n	otiont	Polationship (parent local quardien parsonal	Lyanyagantatiya
Printed name if signed on the behalf of the p		Relationship (parent, legal guardian, personal	•
The records custod	ian has fifteen	n (15) business days to fulfill this reque	est.
For Office Use Only			
Request Received By	Date	Chart ID#	

## KITSAP OBGYN, PLLC

Jorge O Zapata, MD Anita Alvestad-McIntyre, MD Nancy J Bohannon, MD Jennifer C Quimby, MD Kathy J Hebard, MD Amity A Marriott, MD Lori Nelson, ARNP

9750 Levin Rd, Silverdale, WA 98383 Tel: 360-307-7202 Fax: 360-698-6600

## Authorization to Release Information

Pa	tient Name:			Date of Birth:			
Pr	evious Name:			Telephone:			
II.	My Authorization						
	You may disclose the followin	ng health care inf	ormation (	(check all that apply):			
	☐ The most recent records from the last (2) years ☐ Health information from						
	Specific health information	on:					
	YOU MAY RELEASE HEALTH CARE INFORMATION TO:						
	Name (or title) and Organization:						
	Address:		_City:	State: Zip:			
	Telephone Number:			Fax:			
	Reason(s) for this authorizati	on (check all tha	t apply):				
	At my request Tra	`	11 0	other (specify):			
		insterring wiediear	Carc	other (specify).			
III.	My Rights						
	<u>SENSITIVE INFORMATION</u> : I understand that my records may contain information regarding the diagnosis and treatment of HIV (AIDS virus), other sexually transmitted diseases, drugs and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I release the office and its staff from all legal responsibility of liability that may arise from the release of this information. At any time I may revoke this consent, except when the action has been taken.						
	Please check here if you <u>DO NOT</u> want any of the above-mentioned information released. (Checking this box may limit the						
	amount of records that will be sent.)** Please specify the information you DO NOT want released:						
	<u>DISCLOSURE</u> : I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).						
	<u>REVOCATION:</u> I may revoke this authorization in writing by writing a letter to my Health Care Provider at Kitsap OBGYN, PLLC. If I do, it would not affect any actions already taken by Kitsap OBGYN, PLLC based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.						
	EXPIRATION: This authorization ex	pires 90 days after da	ite signed.				
Ī	Patient or legally authorized individual	signature		Date			
Ī	Printed name if signed on the behalf of	the patient		Relationship (parent, legal guardian, personal representation	ve)		
	The records cus	stodian has fifte	een (15) b	ousiness days to fulfill this request.			
	For Office Use Only						
	Request Received By	Date		Chart ID#			