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

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Telephone: _____

I. My Authorization

You may obtain and use the following health care information (check all that apply):

☐ The most recent records from the last (2) years ☐ Health information from _____

☐ Specific health information: _____

YOU MAY REQUEST HEALTH CARE INFORMATION **FROM:**

Name (or title) and Organization: _____

Address:_____City:_____ State:_____ Zip:_____

Telephone Number:_____ Fax: _____

Reason(s) for this authorization (check all that apply):

☐ At my request ☐ Transferring Medical Care ☐ other (specify): _____

II. My Rights

SENSITIVE INFORMATION: 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 *DO NOT* 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:* _____

DISCLOSURE: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

REVOCATION: 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 expires 90 days after date signed.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on the behalf of the patient Relationship (parent, legal guardian, personal representative)

The records custodian has fifteen (15) business days to fulfill this request.

For Office Use Only

Request Received By _____ Date _____ Chart ID#_____

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Authorization to Release Information

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Telephone: _____

II. My Authorization

You may disclose the following health care information (check all that apply):

☐ The most recent records from the last (2) years ☐ Health information from _____

☐ Specific health information: _____

YOU MAY RELEASE HEALTH CARE INFORMATION **TO:**

Name (or title) and Organization: _____

Address:_____City:_____ State:_____ Zip:_____

Telephone Number:_____ Fax: _____

Reason(s) for this authorization (check all that apply):

☐ At my request ☐ Transferring Medical Care ☐ other (specify): _____

III. My Rights

SENSITIVE INFORMATION: 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 *DO NOT* 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:* _____

DISCLOSURE: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

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