KITSAP OBGYN, PLLC

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Authorization to Release Information

Patient Name: ________________________ Date of Birth: ________________________

Previous Name: ________________________ Telephone: ________________________

I. My Authorization

You may disclose the following health care information (check one):

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

☐ Specific health information: ________________________

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

☐ **Self** (please provide current address below) *** Fees may apply.**

Facility/Doctor's Name: ________________________

Address:________________________City:________________________ State:_____ Zip:________________

Telephone Number:________________________ Fax: ________________________

Reason(s) for this authorization (check one):

☐ 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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