**RELEASE OF PATIENT INFORMATION – KITSAP OBGYN PLLC.**

**9750 Levin Road NW Silverdale, WA 98383**

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| **Whose Patient Information is Being Released?** | | | | | | |
| PATIENT NAME | | DATE OF BIRTH | | | | LAST 4 DIGITS OF SS# |
| ADDRESS | | CITY | | | STATE | ZIP |
| **Are we requesting records**  **or sending records to?** | | | | | | |
| REQUEST RECORDS FROM | | SEND RECORDS TO | | | | |
| LOCATION | CONTACT NAME | | **If we are requesting records from you, please return to:**  **Fax: 360-698-6600**  **Attn: Medical Records** | | | |
| NAME/ORGANIZATION | | |
| ADDRESS | | CITY | | | STATE | ZIP |
| PHONE | | | | FAX (healthcare providers only) | | |
| **What Records or Reports Should be Released?**  Dates of Service:  Record Abstract/Summary (History/Physical, Consults, Surgical, Radiology, Discharge Summary)  Discharge Summary  History and Physical  Consultations  Surgical/Procedure Reports  Radiology  Laboratory Results  Pathology Results  Clinic Notes  Billing Records  Last 2 years of medical history  Other: | | | | | | |
| **What Format and Delivery Method Would You Prefer?**  Format:  Paper  Fax  Delivery Method:  Mail  Pick-up  Fax | | | | | | |
| **What is the Purpose of the Release?**  Insurance  Personal  Treatment  Legal  Transfer of Care  Other: | | | | | | |
| *The information disclosed may be subject to re-disclosure by the recipient and will no longer be protected by the Privacy Protections, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164), and the Privacy Act of 1974 (5 USC 552a)*   * I hereby authorize Kitsap OBGYN PLLC. and/or their business partners to disclose release medical records and/or other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable for legal, insurance or personal use. * I hereby release Kitsap OBGYN PLLC. and/or their business partners from any liability which may result from this disclosure of confidential medical information, or which may arise as a result of the information contained in the information released. I understand that I may revoke this authorization by providing written notice of my intention. Unless withdrawn, this consent will expire in ninety (90) days from the date signed.   This information may include Medical/Surgical, Psychiatric, Substance Abuse, Genetic, HIV/AIDS and sexually transmitted disease information.  I authorize that this information may be faxed to the requesting Health Care Provider.  SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: DATE:  IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT: DATE: | | | | | | |

***The records custodian has 15 business days to fulfill this request.***

*For official use only*

*Request Received by: Date: Chart ID#*