

Authorization to Release Medical Records

PATIENT INFORMATION:

Name (print)

DOB

INFORMATION TO BE RELEASED FROM

Best Practices Medical Clinic 5 S. 14th Avenue Yakima, Washington 98902

INFORMATION TO BE RELEASED TO:

Name of designated recipient

Address

City

State

Zip

INFORMATION TO BE RELEASED (check one)

The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)

All medical records

Specific Information (please specify)

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE (please check one)

Attorney

Insurance

Doctor

Personal

PATIENT AUTHORIZATION

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization

EXCLUDE the following information from the records released (please initial)

Drug/alcohol abuse/treatment & diagnosis

sexually transmitted disease

HIV/AIDS diagnosis/treatment/testing

Mental illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

Signature: _____ Date: _____

(Patient, guardian or authorized representative)

This authorization will expire 90 days from the date signed

Possible copying fee required