Olympic Medical Center

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient Name ____ Date of Birth ____/____/____

SS# ______-______-________ Other Last Names Used ________________________________

INFORMATION TO BE RELEASED *FROM:*

I hereby authorize the following organization to release the medical information stated below from the patient's medical record:

☐ Olympic Medical Center **or**

☐ ____ (Organization / Person)
____ (Street Address)
____ (City, State, Zip)
____ (Telephone / Fax #)

INFORMATION TO BE RELEASED *TO:*

☐ ____ (Organization / Person)
____ (Street Address)
____ (City, State, Zip)
____ (Telephone / Fax #)

______ Gordon Fall, MD
______ Mark Lacambra, MD
______ Vara Kraft, MD
______ Kim Wheeling,MD

Olympic Medical Center
7715 24th Ave NW
Seattle, WA 98117
Phone: 206-782-1133 Fax: 206-782-1373

Purpose or reason: ____

TYPE OF INFORMATION **(Check appropriate Box)**	**SPECIFIC RELEASE – REQUIRED**
☐ Most recent 3-year history ☐ Any and all records ☐ Other ________________ __________________________ __________________________	This release **[ ] MAY [ ] MAY NOT** Include specific information related to testing, diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.

AUTHORIZATION:

This authorization may be revoked in writing at any time except to the extent already relied upon, and will expire in 90 days unless previously revoked. 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 of Patient (or other responsible person) Date

______________________________ ____________________________________
Relationship (if not the patient) Signature of Witness