

# Consent To Release Medical Records To MARY'S FAMILY MEDICINE

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ S/S#: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

## I REQUEST/AUTHORIZE MY HEALTH CARE PROVIDER:

Provider Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_

## TO RELEASE PROTECTED HEALTH INFORMATION TO:

**Gina Landicho-Wicks, MD**  
MARY'S FAMILY MEDICINE  
16701 Cleveland Street, Suite 210, Redmond, WA 98052  
Phone: (425) 883-8050 Fax: (425) 885-2058

## FOR THE PURPOSE OF CONTINUED HEALTH CARE.

\*\*\* Information obtained with this authorization will be used solely for the purpose defined above. \*\*\*

My protected Health information may include medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinician office chart reports, laboratory reports, dental records, pathology reports, therapy reports, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization.

**I Authorize Release of:**  All protected Health Information  Specific Information: \_\_\_\_\_

Date(s) of Service for Requested Health Information: \_\_\_\_\_

**I understand that my Provider needs my specific authorization to release information pertaining to the items listed below. By initialing each of the listed items, I authorize release of the information pertinent to my case:**

- Chemical Dependency (includes alcohol/drug treatment)..... (initial)
- Mental Health Information (excluding psychotherapy notes)..... (initial)
- Sexually Transmitted Diseases (including HIV/AIDS)..... (initial)
- Reproductive Health (including abortion)..... (initial)

*I understand that my records are protected under Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations (42 CFR Part 2). I understand that I have the right to withdraw this authorization at anytime, except for action already taken, and that such revocation must be in writing. Further, I understand that this authorization, without prior revocation, will automatically expire 90 days from the date of my signature.*

**REDISCLASURE:** Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by this rule with the exception of the Alcohol and Drug Abuse records which are protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

*I understand that I do not have to sign this authorization in order to receive health care treatment.*

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

(If signed by a personal representative of the patient, please complete the following)

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient:  Parent  Legal Guardian\*\*  Holder of a Power of Attorney\*\*

\*\* Please attach legal documentation if you are the Legal Guardian or Holder of a Power of Attorney