

RELEASING DEPARTMENT: MARY'S FAMILY MEDICINE

16701 Cleveland Street, Suite 210

Redmond, WA 98052

Phone: (425) 883-8050

Fax: (425) 885-2058

Patient A/C #: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth: _____ S/S #: _____ HM Phone: _____ WK Phone: _____

Dates of Service for requested information: _____ to _____ (OR) All Protected Health Info.

I Request/Authorize MARY'S FAMILY MEDICINE To Release Health Care Information To

Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

Purpose of Disclosure (please check one)...

Insurance Attorney Legal Physician Self Other: _____

I Authorize Disclosure/Release Of The Following Medical Information. Please Check All That Apply:

- Sexually Transmitted Disease (STDs)
- AIDS/HIV Diagnoses/Test Report(s)
- Alcohol/Drug Abuse
- Mental Health

HEALTH INFORMATION DISCLOSED / RELEASED

- Pertinent Records (last two years)
- EKG Report(s)
- Billing Record(s)
- Progress Note(s)
- Diagnostic Imaging Report(s)
- Other:
- History and Physical Report(s)
- Laboratory Report(s)
- Immunization Record(s)
- Pathology Report(s)

Mary's Family Medicine, Inc. PS is hereby released from all legal responsibilities or liability for the release of the above-mentioned information. 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 Part2). Staff from Mary's Family Medicine, Inc. PS may discuss my medical conditions and treatment with those persons or organizations listed above. I understand that I have the right to withdraw this authorization at any time, 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 Part2). 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 Part2.

I understand that I do not have to sign this authorization in order to receive Health Care treatment.

Signature: _____ Date: _____

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 of Holder of Power of Attorney