SNOQUALMIE VALLEY CLINIC

AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____ Birth date_____
(Please print full name and any other name records may be under)

hereby authorize: Snoqualmie Valley Clinic
PO Box 2013
38700 SE River St, #400
Snoqualmie, WA 98065
Phone# (425) 888-2299 Fax# (425) 888-1204

to release information contained in my medical records to :

_____
Name Phone

_____
Address City State Zip Code

Information to be disclosed for_____
Reason

_____ Surgery
_____ Pathology
_____ Lab Results
_____ Office Procedures
_____ Treatment Plan
_____ Diagnostic Procedures
_____ All Records
_____ Last 2 Years Notes/Labs
Other:_____

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders and/or mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV, sexually transmitted diseases, psychiatric disorders, mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing and or treatment. _____(Initial)

EXCLUSIONS: IDENTIFY AND SPECIFY PORTIONS OF MEDICAL RECORD YOU DO NOT WISH RELEASED: _____
_____

I understand that my records are protected under Federal and State Confidentially Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations (42 CFR Part2). Staff from my provider listed above may discuss my medical condition and treatment Snoqualmie Valley Clinic. I understand that I have the right to withdraw this authorization at anytime, except for the 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.

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

Signed_____ Printed Name _____

Date_____ Relationship if other than Patient _____