

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Authorization to release medical information regarding:

Patient's Name: _____ Date of Birth: _____

SSN _____ Previous name: _____

I request and authorize:

Name of Organization or Clinic: _____

Physician Name: _____

Address: _____

Phone # _____ **Fax #** _____

to release health care information of the patient named above to:

Queen Anne Obstetrics and Gynecology
Susan M. Petcoff, D.O. Lynne A. Haspedis, D.O.
220 W Mercer Street, Suite #110 Seattle, WA 98119
Phone 206-781-1830 FAX 206-283-3640

FOR THE PURPOSE OF: () Transfer of care () Consultation & Treatment () Other _____

This request and authorization applies to:

Health care information relating to the following treatment, condition, or dates of treatment:

 All health care information

Other: _____

My Rights:

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in research study, or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Queen Anne OBGYN based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the Queen Anne OBGYN. Or
- Write a letter to the Queen Anne OBGYN

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

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/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorder/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

Signature of patient or patient's authorized representative

Date

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

