SEATTLE OB/GYN GROUP
1101 MADISON ST # 950
SEATTLE, WA 98104
(206) 682-5800 PHONE
(206) 233- 9657 FAX

MEDICAL RELEASE AUTHORIZATION
(Please send this to the office that you are transferring from)

NAME: _____
Last First Middle Maiden

TELEPHONE NUMBER: _____BIRTHDATE: _____

Information to be released **FROM**: _____

Address_____
City, State, Zip Code Phone Number

Information to be released **TO**: _____

Address_____
City, State, Zip Code Phone Number

INFORMATION TO BE RELEASED:

- ☐ Transferring Care
- ☐ Moving out of Area
- ☐ Appointment with Specialist
- ☐ Health Insurance Change
- ☐ Personal
- ☐ Continuing Care with PCP
- ☐ Other _____
- ☐ The most recent 2 years of pertinent information or less than 10 pages (Chart notes, labs, x-rays and special tests)
- ☐ All Medical Records
- ☐ Specific Information (please specify): _____

_____

Patient Authorization:
This authorization includes records that may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, genetic testing, or psychiatric treatment. **If I do not want these specific records disclosed, I will cross those items out from the sentence above.**

My Rights:

- I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:
  To take part in a research study or
  To receive health care when the purpose is to create health care information for a third party.
- I understand that I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Seattle OB/GYN Group based upon this authorization. I understand that there are two ways to revoke this authorization:
  Filling out a revocation form. A form is available from Seattle OB/GYN Group. Or
  Writing a letter to Seattle OB/GYN Group (1101 Madison St. Ste 950, Seattle, WA 98104) stating that I revoke this authorization.
- I understand that once health care information is disclosed, the person or organization that receives it may not be required to maintain the confidentiality of my health care information. Therefore, it may be redirected and privacy laws may no longer protect it.

PATIENT'S SIGNATURE: _____ **DATE:** _____
Guardian or Authorized Representative: Please provide documents to prove authority to sign on behalf of the patient.

This authorization will expire 90 days from the date signed

PROLIANCE SURGEONS®