THE
WASHINGTON CENTER
FOR PAIN MANAGEMENT

Authorization for Release of Information

PATIENT INFORMATION

Patient Name (PRINT)	Date of Birth	Phone Number	Last 4 digits of Social Security #
_____	_____	(____)_____	____ ____ ____ ____

YOU MAY RELEASE MY INFORMATION FROM:

_____
Clinic Provider Name

_____
Address

_____
City, State, Zip

(____)_____(____)_____
Fax Phone

YOU MAY RELEASE MY INFORMATION TO:

_____
Name (i.e. Attorney, Provider, Self)

_____
Address

_____
City, State, Zip

(____)_____(____)_____
Fax Phone

INFORMATION TO BE RELEASED:

☐ The most recent **2 YEARS** of pertinent information **(Chart notes, lab reports, x-rays reports and special tests)**
☐ All medical records
☐ Specific information **(Please specify)**: _____

PURPOSE FOR WHICH INFORMATION IS BEING RELEASED (CHECK ONE):

☐ Attorney ☐ Insurance ☐Provider ☐Personal ☐Other (specify):_____

DELIVERY PREFERENCE (CHECK ONE):

☐ Mail Paper Copy ☐ Mail CD ☐Email (Patient requests only): _____
(Please provide a legible email address)

Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

This authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV Infection, alcohol and/or drug abuse, and mental health conditions.

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: _____ **DATE**: _____
Patient, Guardian*, or Authorized Representative
***Please provide documentation to prove authority to sign on behalf of the patient.**

This Authorization will expire on: _____.
Date or Specific Event

If no date/event is given, the authorization shall expire 90 DAYS from the date signed.
Possible copying fee required.

Health Information Department
PO Box 827 Bellevue, WA 98009
***Phone*: 425-774-1538**
***Fax*: 877-809-6099**