Hudson's Bay Medical Group
100 E 33rd Street, Ste. 206
Vancouver, WA 98663
Phone (360) 695-1334 Fax (360) 992-1159

Authorization for Release of Information

Patient Information:
Name: _____ DOB: _____ SS#: _____

Information to be released from: _____
Name of designated Facility or Provider

(____)_____ _____
Fax Address / Phone

Information to be sent to: _____
Name of designated recipient

(____)_____ _____
Fax Address / Phone

Information to be released:
_____The most recent 2 years of pertinent information (chart notes, labs, x-rays, immunizations & special tests)
_____Specific information (please specify):_____
_____

Purpose for which disclosure is being made: (Please check one of the following)
____Attorney ____Insurance ____Transfer Care/New PCP ____Specialist ____Personal Use

Copying Fee: $1.12/page for the first 30 pages plus $0.84/page thereafter. Clerical Labor Fee: $25.00 (not charged to patients). Our office will not pay for records being requested from another physicians' office.

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

***EXCLUDE the following information from the records released (please initial):**
_____Drug/Alcohol Abuse diagnosis/treatment _____Sexually Transmitted Infections
_____HIV/AIDS diagnosis/treatment/testing _____Mental Illness or Psychiatric diagnosis/treatment
_____Genetic Testing

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 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*).
Permission to use secure email _____(Patient Initials)
[*Please provide documents to prove authority to sign on behalf of the patient.] 07/01/15

This authorization will expire 90 days from the date signed

(Privacy Rule 45 CFR 164.506) – Per HIPAA regulations, disclosure of PHI for the purposes of continued treatment, payment or healthcare operations does not require patient authorization.)