AUTHORIZATION TO RELEASE OR REQUEST HEALTHCARE INFORMATION

☐ JEFFREY M. FRANKEL, M.D. ☐ DAVID C. REED, M.D. ☐ JEFFREY L. EVANS, M.D.
16259 Sylvester Rd SW, Suite 303, Burien WA 98166
Phone – 206-244-2822 Fax – 206-243-7807

Patient Name: _____ Date of Birth: _____ Phone: _____
(First - Middle Init. - Last)

REQUEST RECORDS FROM:			RELEASE RECORDS TO:		
Doctor Full Name:			Doctor Full Name:		
Clinic Name:			Clinic Name:		
Street Address:			Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone	Fax		Phone	Fax	

My Authorization: You may use or disclose the following health care information (check all that applies)

- ☐ All health care information in my medical record.
- ☐ Health care information in my medical record relating to the following treatment or condition: _____
- ☐ Health care information in my medical record for the the date(s): _____
- ☐ Other (e.g., X-rays, bills) specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for:
(check all that apply)

- ☐ HIV (AIDS virus)
- ☐ Sexually transmitted diseases
- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use

Reason(s) for this authorization (check all that apply)

- ☐ At my request
- ☐ Other (Specify)

This authorization ends:

- ☐ In 90 days from the date signed ☐ On (date): _____
- ☐ When the following occurs: _____
  (No longer than 90 days from date signed)

My Rights:

I understand I do not have to sign this authorization in order to get 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 may revoke this authorization in writing. If I do, it will not affect any actions already taken by Dr. Jeffrey M. Frankel, Dr. David C. Reed, or Dr. Jeffrey L. Evans based upon this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the physician's office.
- Write a letter to the physician's office.

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

_____ _____ _____
Patient or legally authorized individual signature date time