***Authorization to Release Medical Information TO University Place Medical Clinic***

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (DOB)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I authorize information released FROM:***

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**+++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++**

***I authorize information to be release TO:***

**University Place Medical Clinic**

**4401 Bridgeport Way W**

**University Place, WA 98466**

**PHONE: 253-564-4157 FAX; 253-220-2491**

**Type of Information to be Released**

**General Medical Records**-excluding protected records. Copies of medical records will be limited to two(2) years of information including lab, x-ray unless otherwise requested.

**Specific Information Only:**

**Lab, EKG, Radiology Reports specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Protected or sensitive information:**

***I understand that certain information cannot be released without specific authorization as required by State/Federal law.***

***PLEASE INITIAL EACH BELOW: I authorize the release of the following protected or sensitive information****.:*

\_\_\_\_Drug abuse diagnosis/Treatment \_\_\_\_Sexually Transmitted Diseases

\_\_\_\_Alcoholism Diagnosis/Treatment \_\_\_\_AIDS/HIV Test Results including high

\_\_\_\_Mental Health /Treatment related high risk behavior

\_\_\_\_Genetic Testing

+++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++++

**Do Not Sign Before Reading**

**CAUTION:** *Legal counsel advises that the release of information authorized herein may result in the waiver by the patient of certain legal rights, including the protection of the physician/patient privilege, and rights under the federal alcohol and drug laws related to treatment and Washington laws relating to mental illness, or about tests for treatment of sexually transmitted disease; such as HIV/AIDS. If you have any question about waiving these rights, you are advised to consult your attorney.*

**Date \_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***NOTICE TO PERSONS/ORGANIZATIONS WHO RECEIVE MEDICAL INFORMATION RE-DISCLOSURE PROHITED****:*

*It is an expectation that you will recognize that the information disclosed to you is private information and the re-disclosure without additional patient consent (unless required by law) is prohibited.*

This authorization will expire 90 days from the date of signing or on (*insert applicable date or event)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_