

SAND POINT INTERNISTS

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient Name _____ Date of Birth ____/____/____

SS# _____ - _____ - _____ Other Last Names Used _____

INFORMATION TO BE RELEASED FROM:

I hereby authorize the following organization to release the medical information stated below from the patient's medical record:

Sand Point Internists – Emily Cooper MD, Joan Olson MD, Sarah Pohlmann MD, Anita Uppal MD, Frank Mitchell MD, Donna Richman MD, Vara Kraft MD, Mark Lacambra MD

_____ (Organization / Person)
 _____ (Street Address)
 _____ (City, State, Zip)
 _____ (Telephone / Fax #)

INFORMATION TO BE RELEASED TO:

_____ (Organization / Person)
 _____ (Street Address)
 _____ (City, State, Zip)
 _____ (Telephone / Fax #)

10330 Meridian Ave N #230
Seattle, WA 98133
Phone: 206-524-4737
Fax: 206-524-4740

4915 25th Ave NE #301
Seattle, WA 98105
Phone: 206-524-4737
Fax: 206-522-5236

Purpose or reason: _____

TYPE OF INFORMATION (Check appropriate Box)	SPECIFIC RELEASE – REQUIRED
<input type="checkbox"/> Most recent 3-year history <input type="checkbox"/> Any and all records <input type="checkbox"/> Other _____ _____ _____	This release [<input type="checkbox"/>] MAY [<input type="checkbox"/>] MAY NOT Include specific information related to testing, diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.

AUTHORIZATION:

This authorization may be revoked in writing at any time except to the extent already relied upon, and will expire in 90 days unless previously revoked. 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 of Patient (or other responsible person)

 Date

 Relationship (if not the patient)

 Signature of Witness