

**AUTHORIZATION FOR RELEASE
OF HEALTH INFORMATION**

Patient Information

Name: _____
 Birthdate: _____
 Address: _____

 Phone: _____

Information released by:
 Name: _____
 Address: _____

 Phone: _____
 Fax: _____

Information released to:
 Name: _____
 Address: _____

 Phone: _____
 Fax: _____

This request and authorization applies to:

- All health care information in my medical record.
- Health care information in my medical record for the following dates/treatments:

- Other (e.g. x-rays, bills), specify dates: _____
- I specifically want to **exclude** the following from being used or disclosed: _____

Attention:

I understand that 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, or mental health conditions.

Reason for this authorization: (check all that apply)

- At my request
- I am transferring care
- Other: _____
- Employer
- Financial Institution

This authorization ends:

- In 90 days from the date signed
- Date: _____
- When the following occurs: _____

I understand this authorization may be revoked in writing at any time, except with respect to records that have been sent prior to the revocation. Unless otherwise revoked, this authorization expires in 90 days. I understand that once health care information is disclosed, the person or organization that receives it may re-disclose it.

Fidalgo Island Walk-In Clinic, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein.

Patient or legally authorized signature

Date

Printed name if other than patient

Relationship to patient