

**ADVANCED FAMILY MEDICINE**

2007 152<sup>nd</sup> AVE NE  
Redmond, WA 98052

Phone 425-453-6838  
Fax 425-456-0106

**AUTHORIZATION FOR RELEASE OF INFORMATION**

**Patient information:**

BD: \_\_\_\_\_ SS#: \_\_\_\_\_  
(PRINT name of patient)

**Information to be released FROM:**

Name of designated Facility or Provider \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone Number \_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_  
Fax Number \_\_\_\_\_ City, \_\_\_\_\_ State, \_\_\_\_\_ Zip Code \_\_\_\_\_

**Name of designated recipient**

- Irine Vaiman MD PhD     Jacob (Yakov) Grinberg MD     Vinette Zabriskie MD  
 Roman Kutsy MD     Liubov Endrikhovskaya MD     Nataly Pasymansky DNP

**Information to be released:**

- The most recent 2 years of pertinent information (Chart notes, labs, x-ray and special tests)  
 All medical records  
 Specific information (Please specify): \_\_\_\_\_

**Purpose for which disclosure is being made: (Please check one of the following)**

- Attorney     Insurance     Doctor     Personal

**Patient Authorization:**

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, 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/treatment & diagnosis    \_\_\_\_\_ Sexually Transmitted Disease  
\_\_\_\_\_ HIV/AIDS diagnosis/treatment/testing    \_\_\_\_\_ Mental Illness or Psychiatric diagnosis/treatment

**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 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: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Patient, Guardian\*, or Authorized Representative\*).

[\*Please provide documents to prove authority to sign on behalf of the patient.]

**This authorization will expire 90 days from the date signed.**  
*Possible copying fee required*