ADVANCED FAMILY MEDICINE, PLLC

AUTHORIZATION FOR RELEASE OF INFORMATION

2007 152nd Ave NE
Redmond, WA 98052

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

Patient information:

_____ DOB: _____
(**PRINT** name of patient)

Information to be released FROM: _____
Name of Facility or Provider we are Requesting FROM

(____)_____ _____
Phone Number **Address**

(____)_____ _____
Fax Number **City,** **State,** **Zip Code**

Name of designated recipient

☐ ***Irine Vaiman, MD PhD*** ☐ ***Vinette Zabriskie, MD*** ☐ ***Liubov Endrikhovskaya, MD***
☐ ***Jacob (Yakov) Grinberg, MD*** ☐ ***Natalia Pasumansky, DNP***

Information to be released: (Please check one)

☐ 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 the disclosure is being made: (Please check one)

☐ 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