Authorization to Disclose Protected Health Information (Form)

BelRed Family Medicine PLLC dba Advanced Family Medicine | 2007 152nd Ave NE, Redmond, WA 98052 | Phone 425-453-6838 | Fax 425-456-0106

1. Patient Name: _____ Date of birth: _____ Phone: _____ Address: _____

2. Direction I authorize Advanced Family Medicine to: [ ] RELEASE my records TO [ ] OBTAIN my records FROM:

Name/organization: _____ Address: _____
Phone: _____ Fax: _____

3. Information to be disclosed [ ] All records from _____ to _____ [ ] Only: [ ] Visit notes [ ] Labs [ ] Imaging [ ] Immunizations [ ] Other: _____

4. Specially protected information (initial each category you authorize; if not initialed, it will be withheld)
____ Mental health ____ Substance use disorder treatment (42 CFR Part 2) ____ HIV/AIDS and sexually transmitted infections ____ Reproductive and sexual health

5. Purpose [ ] Continuing care [ ] Insurance [ ] Legal [ ] At my request (personal) [ ] Other: _____

6. Expiration This authorization expires on _____ or upon this event: _____. If left blank, it expires 90 days after signature.

7. Your rights

- You may revoke this authorization in writing at any time, except to the extent we have already acted on it.
- Your treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this form.
- Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy law, although Washington law and 42 CFR Part 2 may limit re-disclosure of certain information.
- You are entitled to a copy of this signed form. A copy or fax is as valid as the original.

Minors: Under Washington law, minors who consented to their own care (mental health and substance use from age 13, STI/HIV from age 14, reproductive health at any age) must sign for release of those records.

Signature of patient or legal representative: _____ Date: _____

Printed name: _____ Authority/relationship (if representative): _____