AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Belred Family Medicine PLLC dba Advanced Family Medicine PLLC 2007 152nd Ave NE, Redmond, WA 98052 **Ph:** (425) 453-6838 | **Fax:** (425) 456-0106

1. PATIENT IDENTIFICATION

Patient Name_______________________________________**DOB:** _________________

Address: ___________________________**City/State/Zip:** _________ **Phone:** ________

2. DISCLOSURE DIRECTION

I authorize **Belred Family Medicine DBA Advanced Family Medicine of Redmond** to:

[ ] **OBTAIN** records from: [ ] **RELEASE** records to:

Name/Organization: ____

Address: ____

Phone: ___________________________ **Fax:** ____________________________

3. SCOPE OF INFORMATION

[ ] **All Records** (Last 2 years) [ ] **Specific Dates of Service:** From_________ To________

[ ] **Specific Records only:** (e.g., Labs, Imaging, Immunizations) ______________________

4. SENSITIVE INFORMATION AUTHORIZATION (REQUIRED)

Initialing below expressly authorizes the release of information that is otherwise specially protected under WA State Law: __**Mental Health** treatment records____ **Substance Use** (Drug/Alcohol) treatment records____ **HIV/AIDS** testing or treatment ____ **Sexually Transmitted Disease** (STD) ____ **Reproductive Health** (for minors)

5. PURPOSE OF DISCLOSURE

[ ] Continuity of Care [ ] Insurance Claim [ ] Legal [ ] Personal Use [ ] Other: _______

Minors (WA Law): Patients aged **13+** must sign for Mental Health/Substance Use; **14+** for STDs/HIV; and any age for Reproductive Health records.

Signature of Patient/Representative: ___________________________ **Date:** _________

Printed Name: ______________________________ **Relationship to Patient:** _________