

Office Use only
Date received: _____
Provider Initials: _____
Date released: _____
Staff initials who sent info _____

LAKESHORE CLINIC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____
(First) (Middle) (Last) (Previous Name)

Address: _____

Date of Birth: _____ Home/Work Phones: _____ Social Security Number _____

My Physician at Lakeshore Clinic is Dr. _____

Release Records From Lakeshore Clinic To:		Release Records To Lakeshore Clinic From:
_____		_____
(Name)		(Name)
_____	OR	_____
(Address)		(Address)
_____		_____
(City) (State) (Zip)		(City) (State) (Zip)
_____		_____
(Phone Number) (Fax Number)		(Phone Number) (Fax Number)

Reason for record request: _____

IMPORTANT - You may disclose health care information regarding testing, diagnosis, and treatment for (check yes or no):

() Yes () No HIV (AIDS virus)

() Yes () No Sexually transmitted diseases

() Yes () No Psychiatric disorders/mental health

() Yes () No Drug and/or alcohol use

Information to be released (be specific):

Last 2 years of records

Last 5 years of records

X-ray (specify dates) _____

Only dates of service from _____ to _____

Other records (specify) _____

This authorization expires within 90 days of being signed. If you wish to have the authorization expire before 90 days please indicate the date of expiration: _____

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Lakeshore Clinic based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Lakeshore Clinic, or
- Write a letter to Lakeshore Clinic.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship (parent or legal representative)

12710 Totem Lake Blvd NE
Kirkland, WA 98034
(425) 821-4040, FAX (425) 820-5060

10025 NE 186th Street
Bothell, WA 98011
(425) 486-9131, FAX (425) 486-9490