

AUTHORIZATION TO RELEASE PATIENT INFORMATION

PATIENT IDENTIFICATION

Patient Name _____ Date of Birth ____/____/____

SS# _____ - _____ - _____ Other Last Names Used _____

INFORMATION TO BE RELEASED FROM:

I hereby authorize the following organization to release the medical information stated below from the patient's medical record:

_____ (Organization / Person)
 _____ (Street Address)
 _____ (City, State, Zip)
 _____ (Telephone / Fax #)

INFORMATION TO BE RELEASED TO:

_____ (Organization / Person)
 _____ (Street Address)
 _____ (City, State, Zip)
 _____ (Telephone / Fax #)

Women's Cancer Care of Seattle
Howard Muntz, MD
Kathryn McGonigle, MD
 1560 N 115th St., Suite 101 - Seattle, WA 98133
 Ph: 206-368-6806 ▪ Fax: 206-368-6808

Purpose or reason: _____

<p>TYPE OF INFORMATION (check all that apply):</p> <p>____ Dr. Muntz's clinic notes, OP notes and pathology reports</p> <p>____ Dr. McGonigle's clinic notes, OP notes and pathology reports</p> <p>____ Recent H&P, problem list, med list and any other notes pertaining to condition being referred to Women's Cancer Care of Seattle.</p> <p>Other _____</p>

<p>SPECIFIC RELEASE - REQUIRED</p> <p>This release [<input type="checkbox"/>] MAY [<input type="checkbox"/>] MAY NOT Include specific information related to testing, diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.</p>
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AUTHORIZATION:

This authorization may be revoked in writing at any time except to the extent already relied upon, and will expire in 90 days unless previously revoked. 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 of Patient (or other responsible person) _____ Date

 Relationship (if not the patient) _____ Signature of Witness