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AUTHORIZATION FOR RELEASE OF INFORMATION

(Name and address of individual/facility) For the purpose of	I,	, hereby authorize
(Name and address of individual/facility) For the purpose of	(Patient Name)	(Name of facility)
For the purpose of	to provide to	
Pertinent Records Discharge summary Lab reports Operative report Diagnostic imaging Injection reports Physical therapy notes Other (specify) Injection reports Other (specify) Inderstand that the information used or disclosed may be subject to re-disclosure by the recipient. This authorization is valid for 90 days unless revoked in writing. I understand that I have a right to revoke my authorization at any time, and that my revocation must be in writing to be valid, except as documented in the Washington State Healthcare Information Act (Section 203) and unless the disclosure is required to obtain payment for care that has already been rendered. This revocation will become a permanent part of my record. I consent to transmitting via facsimile this information in an emergency situation. Signature Date/Time Date of Birth /		
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Lab reports Operative report Injection reports Injection reports Physical therapy notes Office visit note Other (specify) I understand that the information used or disclosed may be subject to re-disclosure by the recipient. This authorization is valid for 90 days unless revoked in writing. I understand that I have a right to revoke my authorization at any time, and that my revocation must be in writing to be valid, except as documented in the Washington State Healthcare Information Act (Section 203) and unless the disclosure is required to obtain payment for care that has already been rendered. This revocation will become a permanent part of my record. I consent to transmitting via facsimile this information in an emergency situation. Signature Date/Time [patient/guardian/legal representative]	For the dates of service	
Diagnostic imaging Injection reports Physical therapy notes Office visit note Other (specify) Other (specify) I understand that the information used or disclosed may be subject to re-disclosure by the recipient. This authorization is valid for 90 days unless revoked in writing. I understand that I have a right to revoke my authorization at any time, and that my revocation must be in writing to be valid, except as documented in the Washington State Healthcare Information Act (Section 203) and unless the disclosure is required to obtain payment for care that has already been rendered. This revocation will become a permanent part of my record. I consent to transmitting via facsimile this information in an emergency situation. Signature Date/Time Date of Birth / Print patient name Date of Birth / /	Pertinent Records	Discharge summary
History & physical Physical therapy notes Office visit note Other (specify) I understand that the information used or disclosed may be subject to re-disclosure by the recipient. This authorization is valid for 90 days unless revoked in writing. I understand that I have a right to revoke my authorization at any time, and that my revocation must be in writing to be valid, except as documented in the Washington State Healthcare Information Act (Section 203) and unless the disclosure is required to obtain payment for care that has already been rendered. This revocation will become a permanent part of my record. I consent to transmitting via facsimile this information in an	Lab reports	Operative report
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	(patient/guardian/leg	ral representative)
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	Address & Phone	