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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize _____
(Patient Name) (Name of facility)

to provide to _____
(Name and address of individual/facility)

For the purpose of _____

For the dates of service _____

___ Pertinent Records
___ Lab reports
___ Diagnostic imaging
___ History & physical
___ Office visit note
___ Discharge summary
___ Operative report
___ Injection reports
___ Physical therapy notes
___ 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)

Print patient name _____Date of Birth ____/_____/_____

Address & Phone _____

_____