Authorization to Release Health Care Information

Instructions

Failure to follow instructions can result in a delay in processing your request.

1. Print name of patient, birth date and Social Security number of patient for whom the medical records are being requested.
2. Print name of physician, provider, or organization or person that is being asked to disclose copies of the records.
3. Print name, address and phone number of organization or person that is to receive the copies of the information.
4. Check box(s) to indicate what information is to be disclosed:
   a. Information for most recent 2 years of visits.
   b. All outpatient visits for the specific time frame indicated.
   c. All records related to the course of treatment, diagnosis, procedure or condition indicated, form request, other.
   d. Email communication
5. Check the box that applies to the reason the records are being requested.
6. Sign and indicate date signed.
7. Minors between ages of 13 and 17 must authorize the release of certain information concerning the minor.
8. Indicate date for the authorization to expire if it is to be different than 90 days from date of signing.

Charges

There is no charge for copying your medical records if you have the copies sent directly to a health care facility or provider for continuing or transfer of care. If you are requesting copies of medical records for yourself, you will get the first six pages free of charge. Additional pages will result in a copy fee being applied. In addition, postage and sales tax may be charged. You may be invoiced or required to pay applicable fees prior to obtaining the copies. Payment is otherwise due upon receipt of your copies. If charges exceed $25, payment may be required prior to receipt. Information disclosed pursuant to this authorization will not be redacted. Additional fees may apply if redaction is required.

Contact us at 425.908.9394 to request your copies of your medical record, for information about copy charges and/or questions related to copying health information from your medical record.

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1. Individual information:

Patient name: _____ SS#: _____ - _____ - _____ Date of Birth _____ / _____ / _____

2. Information may be disclosed by:

Name of provider, or organization releasing information: _____

Address: _____ Suite/Apt#: _____

City: _____ State: _____ Zip: _____

Fax Number: _____

3. Information may be disclosed to:

Name of organization or person to receive information: Dr. Anna Martin

Address: _____ Suite/Apt#: _____

City: _____ State: _____ Zip: _____

Daytime phone: (425) 908.9394 Fax: (425) 249.7535

4. What kind of information do you want disclosed? (Check box, copy fees may apply)

☐ All records from the last 5 years of visits

☐ Information from date _____ / _____ / _____ to date _____ / _____ / _____

☐ Email Communication: _____

☐ Other: _____

5. Why are you asking for this health information to be released? (Check *one* box)

☐ Attorney ☐ Insurance ☐ Doctor ☐ Medical leave ☐ Personal ☐ Other _____

Authorization

Information released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness. I give my specific authorization for this information to be released.

_____ initials

Rights

Generally, BiofXN, PLLC and any other entity covered by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I may revoke this authorization in writing. Once the information I have authorized to be disclosed is disclosed, it may no longer be protected under health information privacy laws. If I revoke my authorization, it will not affect any actions already taken by BiofXN, PLLC based upon this authorization.

Signatures

_____ _____

Patient or Guardian, or Authorized Representative **Date**
(Documentation may be required to prove authority to sign on behalf of the patient)

_____ _____

Minor Signature (requied if minor is age 13-17) **Date**

This authorization expires 90 days from the date signed ***or*** on the date or event indicated here: _____