SEQUIM MEDICAL ASSOCIATES **Authorization to Obtain Information**

I, ________________________, the *PATIENT / LEGAL REPRESENTATIVE* hereby authorize the following:

Organization/Provider: ____

Address: __________________________________City ___________________State _____Zip ________

Phone #: __________________________Fax #: ____________________________

TO RELEASE INFORMATION FROM THE HEALTH RECORD OF:

Patient Name: First _______________________MI_________Last________________________________

Previous Name (s): ____

Date Of Birth: ____

Send To: Sequim Medical Associates
840 N. 5th Ave, Suite 2100
Sequim, WA 98382

PH: (360) 582-2850 FAX: (360) 582-2851
Physician Name: ______________________

****If more than 30 pages please mail DO NOT SEND VIA FAX****

DATES TO BE OBTAINED
___ Most Recent two years
___ Most Recent five years
___ All dates
___ Specific Dates:
from ___/___/___ to ___/___/___

INFORMATION TO BE OBTAINED	
___ ALL RECORDS	___LAB REPORTS
___ CHART NOTES	___XRAY
___ EKGS	___MEDICATION LIST
___ CONSULTS	___ IMMUNIZATIONS
___ SPECIFIC ITEMS: ____	

FOR THE PURPOSE OF: ☐ Continuing Care ☐ Insurance Billing
☐ Transfer of Care ☐ Other ____

SENSITIVE INFORMATION: I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health information relating to such diagnosis, testing or treatment.

DISCLOSURES: I understand that authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be re-disclosed by the recipient.

REVOCATION: I understand that I may revoke this authorization at any time by notifying the Business Manager at Sequim Medical Associates in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

EXPIRATION: This authorization will expire when the request has been filled.

X____
Patient/Legal Representative Signature DATE

____
Relationship (if other than patient) PHONE #