



AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION to NW Asthma & Allergy

Patient name _____ Date of birth ____/____/____

Previous name (if any) _____

I am requesting that _____ (organization)

fax #: _____ phone #: _____

Send a copy of my healthcare records to NW Asthma & Allergy Center, fax # 206.527.2514

mailing address: 9725 Third Ave NE, Suite 500, Seattle, WA 98115

Information to be Released (check all that apply)

- Most recent 2 years office visits, All office visits, Testing, Other (specify), lab results, imaging (CT, xrays, etc)

**Please check any of the following health care information regarding testing, diagnosis, and treatment you wish to exclude:

- HIV (AIDS virus), Sexually transmitted diseases, Psychiatric disorders/mental health, Drug and/or alcohol use

Purpose of Release

Reason(s) for this authorization (check all that apply):

- Self, Doctor, Attorney, Insurance, Other (specify)

This authorization ends:

- On (date), When the following event occurs, In 90 days from the date signed

Release Requiring Specific Consent

Minors- A minor patient's signature is required in order to release the following information: 1) Conditions relating to reproductive care including but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS (age 14 and older); and 2) Mental health conditions (age 13 and older); and 3) Drug and alcohol abuse diagnosis or treatment (this information is subject to Federal Regulation 42 CFR Part 2). I specifically authorize information to be released as checked below:

- Reproductive Care, Sexually Transmitted Diseases (incl. HIV/AIDS), Mental Health/Illness, Drug/Alcohol Abuse

Signature of Minor Patient

Date

Time

Signature Required for Release of Information

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study; or To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Northwest Asthma & Allergy Center based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Northwest Asthma and Allergy Center, Inc. Or Write a letter to Northwest Asthma and Allergy Center, Inc.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)