SleepMedicineAssociates

Seattle – Cherry Hill
James Tower – Level A
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Issaquah
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Issaquah, WA 98027
(425) 394-0024

Clinic at Northwest Hospital
McMurray Building
1536 N 115th Street
Seattle, WA 98133
(206) 386-4744

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: ____ to disclose the following information
(Name of Provider or Organization)
from the health records of:

Patient Name: ____ *(Last, First, Middle)*
Previous Name: ____ *(Last, First, Middle)*
Address: ____
City: __________________________________ State: __________________ Zip: ____________________
Telephone: (______) ________________________ Social Security Number: __________________________
Birth date: _____________________________ Dates of Medical Care: ____________________________
To be disclosed to: ____ *(Name)*
(one recipient only) ____ *(Attention)*
____ *(Address)*
____ *(City, State, Zip)*
(_____) ____________________ *(Telephone)* (_____) _________________________ *(Fax)*

Information to be disclosed:

_____History & Physical
_____Discharge Summary
_____Operative Report
_____Diagnostic Studies (Labs, X-ray, EKG, etc.)
_____Progress (Chart) Notes
_____Emergency Department Report
_____Other ___________________________

For the purpose of: ____

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV Infection, alcohol and/or drug abuse and mental health conditions.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization expires in 90 days.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.

I understand that except in limited circumstances, such as research-related treatment or treatment that is solely for the purpose of disclosing health information to a third party, I am not required to sign this authorization in order to receive treatment.

Signed: ____ Date: __________________
(Patient)

____ Date: __________________
(or Legal Representative and Relationship)