

Valley Women's Clinic
Authorization for Release of Information

17722 Talbot Road South
Renton, WA 98055-5744
Medical Records Department: 425-271-4303 Fax: 425-271-2566

Patient Information: Print name: _____ Date of Birth: _____

SS#: _____ Maiden or prior name: _____

Please release my healthcare information from:

Name of Facility/Provider: _____

Address: _____

City/State/Zip _____

Phone Number: _____

Please send my healthcare information to:

Name designated recipient: _____

Address: _____

City/State/Zip _____

Phone Number: _____

Information to be released

- The most recent 2 years of pertinent information (chart notes, labs, ultrasounds and special tests)
- All medical records
- Specific information (please specify)

Purpose for which disclosure is being made:

Sharing with other health care providers

Personal use

Legal investigation

I am transferring my care to a new health care provider

Other: _____

Patient Authorization

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Valley Women's Clinic is specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

My Rights

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Fees for Copying Medical Records

Valley Women's Clinic will continue to provide one complimentary copy of a patient's medical record to another health care provider (exceptions, of course, for emergency situations)

However, as of July 24, 2003, copies of medical records requested by patients are no longer free. Our charges are as follows: \$20.00 fee for searching for and handling records; 88 cents per page for the first 30 pages and 67 cents per page for all other pages. This fee must be paid before your records can be released. (RCW70.02.10) (12)

I understand that I may be charged at the rates shown above for the copies of the records I have requested and for postage, if needed. I agree to pay the total charges upon receipt of the copies.

Signature: _____ Date: _____

(Patient, Guardian, Authorized Representative* - * Please provide documents to prove authority to sign on behalf of the patient)*

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED