AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Seattle Jaw Surgery 600 BROADWAY,
SUITE 460 SEATTLE, WA 98122
(206) 207-1525

Samuel Bobek DMD, MD, FACS
Andrea Burgess PAC

I give Seattle Jaw Surgery permission to ☐ **release to** ☐ **obtain from:**

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

The medical records of:

Last name: _____ First name: _____ Middle/Maiden: _____

Address: _____

Date of Birth: _____ Contact #: _____

Containing the following information (specify dates):

☐ All Medical Records _____ ☐ Discharge Summary _____

☐ ER Records _____ ☐ Operative Report _____

☐ Lab/EKG _____ ☐ Imaging _____

☐ History & Physical _____ ☐ Other _____

I understand my records may contain information regarding diagnosis or treatment of substance abuse, HIV/AIDS, sexually transmitted diseases or mental/psychiatric illness. Exclude the following information from the records released:

☐ Mental health/psychiatric records ☐ Substance abuse records ☐ Sexually transmitted diseases ☐ HIV (AIDS virus)

For the purpose of: ☐ Continued care ☐ Attorney ☐ Personal ☐ Other: _____

PATIENT RIGHTS: I understand that I have the right to withdraw this authorization at any time, except for action already taken, and that such revocation must be in writing. Contact Seattle Jaw Surgery for a revocation form or write a letter of revocation.

Release of information authorized herein may result in the waiver by the patient of certain legal rights, including the protection of the physician/patient privilege.

REDISCLOSURE PROHIBITED: 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.

I understand that I do not have to sign this authorization in order to receive healthcare benefits.

_____ _____ _____

Signature of Patient or Legally Responsible Party *(A minor patient's signature may be required)* **Authority to sign, if not Patient** **Date (MM/DD/YR)**

This authorization expires in 90 days from the date signed or on the following day/event: _____

You may be charged a fee for processing and copying of your medical records in compliance with the Washington State Uniform Health Care Information Act, RCW 70.02 section 102 (12), and an authorization does NOT have to be honored until the fees are paid.