University Place Medical Clinic

4401 Bridgeport Way W.
University Place, WA 98466
T: (253) 564-4157
F: (253) 220- 2491
www.universityplaceclinic.com

Authorization to Release Medical Information TO University Place Medical Clinic

Patient Name:_____ (DOB)_____

I authorize information released FROM:

Name_____

Address_____

City_____**State**_____**ZIP**_____

PHONE_____ **FAX**_____

++

I authorize information to be release TO:

University Place Medical Clinic
4401 Bridgeport Way W
University Place, WA 98466
PHONE: 253-564-4157 FAX; 253-220-2491

Type of Information to be Released

☐ **General Medical Records**-excluding protected records. Copies of medical records will be limited to two(2) years of information including lab, x-ray unless otherwise requested.

Specific Information Only:

☐**Lab, EKG, Radiology Reports specify**_____

☐**Other** _____

Protected or sensitive information:

I understand that certain information cannot be released without specific authorization as required by State/Federal law.

PLEASE INITIAL EACH BELOW:_____I authorize the release of the following protected or sensitive information.:

____Drug abuse diagnosis/Treatment
____Alcoholism Diagnosis/Treatment
____Mental Health /Treatment
____Genetic Testing
____Sexually Transmitted Diseases
____AIDS/HIV Test Results including high related high risk behavior

++

Do Not Sign Before Reading

CAUTION: *Legal counsel advises that the 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, and rights under the federal alcohol and drug laws related to treatment and Washington laws relating to mental illness, or about tests for treatment of sexually transmitted disease; such as HIV/AIDS. If you have any question about waiving these rights, you are advised to consult your attorney.*

Date _____ **Signature** _____

NOTICE TO PERSONS/ORGANIZATIONS WHO RECEIVE MEDICAL INFORMATION RE-DISCLOSURE PROHITED:

It is an expectation that you will recognize that the information disclosed to you is private information and the re-disclosure without additional patient consent (unless required by law) is prohibited.

This authorization will expire 90 days from the date of signing or on (*insert applicable date or event*) _____