

ISLAND HOSPITAL – 1211 24TH ST. – ANACORTES, WA 98221 – (360)-299-1300

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|---|---|---|--|
| <input type="checkbox"/> ANACORTES FAMILY MED.
2511 M AVE., SUITE B
ANACORTES, WA 98221
(360) 299-4211 | <input type="checkbox"/> FIDALGO MEDICAL ASSO.
1213 - 24TH ST., SUITE 100
ANACORTES, WA 98221
(360) 293-3101 | <input type="checkbox"/> ISLAND PCC/ATC
1211 - 24 TH ST.
ANACORTES, WA 98221
(360) 293-6973 | <input type="checkbox"/> LOPEZ ISLAND MED. CLINIC
P.O. BOX 10
LOPEZ ISLAND, WA 98261
(360) 468-2245 |
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I authorize the release of medical records kept for: _____
Name: Last First Middle Initial Date of Birth

To be released from: Island Hospital Other _____
(Please provide organization's name and address)

And sent to: _____
Person / Organization / Address

For the purpose of: Insurance Health care provider Attorney Personal

Records requested include the following: Summary of treatment X-Ray reports or films
 Lab test reports Other _____

For the time period _____ To _____

Expiration date or event _____

Patient authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

Exclude the following information from the records to be released (please initial as appropriate):

_____ Drug/alcohol abuse treatment & diagnosis _____ Sexually transmitted disease
_____ HIV/AIDS diagnosis / treatment / testing _____ Mental illness or psychiatric diagnosis / treatment

If patient has reached his/her 13th birthday, only the patient may authorize the disclosure of information relating to mental health, alcoholism or drug abuse.

If patient has reached his/her 14th birthday, only the patient may authorize the disclosure of information relating to pregnancy, pregnancy termination, sterilization or sexually transmitted disease (including HIV/AIDS).

My rights:

I understand 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, I may read the Notice of Privacy Practices posted at the facility from which my 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.

Signature _____ Date _____
(Patient, Guardian*, or Authorized Representative*)

[*Please provide documents to prove authority to sign on behalf of patient.]

Date Records Copied _____ Copied By _____ Department/Clinic _____