AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information:

_____DOB:_____SS#:_____
(PRINT name of patient)

Information to be released from:_____
Name of Designated Facility or Provider

_____
Address

Information to be sent to: **Joseph E. Chebli, MD**
10330 Meridian Avenue North
Suite 390
Seattle, WA 98133
Fax: (206) 368-1228

Information to be released:

☐ The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)

☐ All medical records

☐ Specific Information (Please Specify):
_____
_____

Purpose for which disclosure is being made: (Please circle one of the following)

Attorney Insurance Doctor Personal

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 specific authorization for these records to be released.

_____*EXCLUDE the following information from the records released (please initial):
_____ Drug/Alcohol abuse/treatment & Diagnosis _____Sexually Transmitted Disease
_____HIV/AIDS diagnosis/treatment/testing _____Mental Illness or Psychiatric diagnosis/treatment

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 of revoking the 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.

SIGNATURE: _____ DATE:_____
(Patient, Gaurdian*, or 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. Possible copying *fee* required.