6839 Fort Dent Way, Suite 134
Tukwila, WA 98188
Phone (206) 812-9988
Fax (206) 812-9989

Authorization for Release of Medical Information

Patients Name: ____ Date of Birth: _______________

Address: ____

City: ___________________________State: _______________ Zip Code: ____________________

Patients Phone#:___________________________________

Date Requested: ______________________ Date Needed _______________________

Please choose one

Tahoma Clinic to Released to [ ]   Tahoma Clinic to Obtain from [ ]

Name of Provider or Facility: ____

Address: ____

City: __________________________ State: ____________________ Zip Code: ____________

Phone: ________________________________ Fax: ___________________________________

Type of records requested

[ ] The most recent 2 years of pertinent information (chart notes, Labs)

[ ] All Medical Records

[ ] Specific Information: _____________________________________

I Understand that:

* My right to healthcare treatment is not conditioned on this authorization.
* I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
* If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
* Release of HIV-related information, mental health related care, of substance abuse diagnosis and treatment information requires additional authorization.
* There may be a charge for the requested records.

Signature of Patient or Representative______________________________________

Relationship to patient (if requester is not the patient)___________________________

Date______________________