Tahoma Clinic North Seattle
2611 NE 125th Street, Suite 228
Seattle, WA 98125
206-402-4215 Office
206-257-4468 Fax

Authorization for Release of Medical Information

Patient Name (Please Print) _____ D.O.B. _____
Address _____

_____

Patient Number_____

☐ I Authorize Tahoma Clinic North Seattle to release my information TO:	☐ I Authorize Tahoma Clinic North Seattle to OBTAIN information FROM:
_____ Name of Provider (first/Last name) or Facility	_____ Name of Provider (first/Last name) or Facility
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Phone _____ Fax	_____ Phone _____ Fax

PURPOSE FOR THIS REQUEST: [ ] Transfer of Care [ ] Insurance [ ] Personal [ ] Other

[ ] Please fax back Attention: _____

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, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

Signature of Patient or Representative _____ Date _____

Relationship to Patient (If requester is not the patient) _____ Date _____