TAHOMA CLINIC

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

Authorization for Release of Medical Information

IF FAXING OVER 50 PAGES PLEASE MAIL RECORDS

Print Full Name of Patient: _____Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Patients Primary Phone #:_____

Date Requested: _____ Date Needed _____

Please choose one

Tahoma Clinic to **Release 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, Lab results, Scans)
[ ] 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)_____

Today's Date_____/_____/_____