AUTHORIZATION TO RELEASE MEDICAL RECORDS
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE IS REQUIRED

Patient's Name: _____ DOB: _____
Phone Number: _____ SS #: _____
Address: _____
Previous Address: _____

I, the undersigned, do authorize and request
_____
_____
to release my medical records to:

Lake Washington Primary Care, PLLC
8015 SE 28th Street, #310
Mercer Island, WA 98040
Phone: 206-898-2416 Fax: 877-771-1073

I, the undersigned, do authorize and request Lake Washington Primary Care, PLLC to release my medical records to:
_____
_____
_____
_____
_____

Please state specifically what information should be released: _____
_____

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Relationship, if **NOT** the patient Date

This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken, and if not earlier revoked, this consent shall become invalid ninety days from the date of signature. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above. I understand that I may review the disclosed information by contacting the physician, institution or agency named above. I understand that I have the right of the patient to inspect the disclosed material.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to: (check the appropriate box)*

- ☐ Substance Abuse (alcohol/drug abuse)
- ☐ Mental Health (includes psychological testing)
- ☐ HIV - Related Information (AIDS related testing)

*In order for this information to be released, you must sign here ***and*** above and check the appropriate box(es).

_____ _____
Signature of Patient or Legal Guardian Date