

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Authorization to release medical information regarding:

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN \_\_\_\_\_ Previous name: \_\_\_\_\_

I request and authorize: **Queen Anne Obstetrics and Gynecology**  
**Susan M. Petcoff, D.O. Lynne A. Haspedis, D.O.**  
**220 W Mercer Street, Suite #110 Seattle, WA 98119**  
**Phone 206-781-1830 Fax 206 283-3640**

to release health care information of the patient named above to:

**Name of Organization or Clinic:** \_\_\_\_\_

**Physician Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone and Fax Number:** \_\_\_\_\_

For the purpose of : ( ) Transfer of care ( ) Consultation & Treatment ( ) Other \_\_\_\_\_

**This request and authorization applies to**

Health care information relating to the following treatment, condition, or dates of treatment:

\_\_\_\_\_

All health care formation

Other: \_\_\_\_\_

**My Rights:**

I understand I do not have to sign this authorization in order to get healthcare benefits(treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in research study, or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Queen Anne OBGYN based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the Queen Anne OBGYN. Or
- Write a letter to the Queen Anne OBGYN

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorder/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

\_\_\_\_\_  
Signature of patient or patient's authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)