



100 E 33rd St, Ste. 206A
Vancouver, WA 98663
Phone (360) 695-1334,
Fax (360) 992-1159
Fax for Chart Notes Only: (360) 707-7453

Patient Name: _____

Date of Birth: _____

Authorization for Release of Information

Information to be released from: _____	
Name of Designated Facility or Provider	
() _____	_____
Fax	Address / Phone

Information to be released to: _____	
Name of Designated Facility or Provider	
() _____	_____
Fax	Address / Phone / Email

Information to be Released: ☐ Last 2 years

OR, if looking for specific information:

- | | | | |
|---|--|--|--|
| ☐ Immunization Records | ☐ Lab/Pathology Reports | ☐ Procedure Reports | ☐ History and Physicals |
| ☐ Medication List | ☐ Imaging Reports | ☐ Progress Notes | ☐ Discharge Summaries |
| (DO NOT send CD's with images unless requested) | | ☐ Other: _____ | |

Purpose of Disclosure: (check one)

- ☐ Attorney/Insurance ☐ Transfer Care/New PCP ☐ Specialist/Continuity of Care ☐ Personal

Method of Disclosure: (check one)

- ☐ Fax (default method) ☐ Mail ☐ Email ☐ CD ☐ Pick-Up In Person

*** Incoming Records: if page count is greater than 75 pages, please send via CD

By signing this authorization, I understand that:

- My records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted infections, drug and/or alcohol abuse, mental illness, or genetic testing. I give my specific authorization for these records to be release unless initialed below:

*If you wish to EXCLUDE the following information from the records released, please initial the lines below.

_____ Drug/Alcohol Abuse diagnosis/treatment	_____ Sexually Transmitted Infections
_____ HIV/AIDS diagnosis/treatment/testing	_____ Mental Illness or Psychiatric diagnosis/treatment
_____ Genetic Testing	

- I do not have to sign this authorization to obtain health care benefits (treatment, payment, or enrollment).
- I may revoke this authorization in writing. If this authorization is revoked, HBMG cannot undo disclosures already released under this authorization.
- Unless revoked, this authorization will expire (90) ninety days from the date signed.
- Any disclosure of information has the potential for re-disclosure and may not be protected by federal confidentiality laws.
- I may ask for a copy of this authorization.
- There may be a fee associated with my request. RCW 70.02.030, 45 CFR 164.524

Patient or Legally Authorized Representative* Signature

Date

Relationship to Patient if signed on Behalf of Patient

Printed Name if Signed on Behalf of Patient

[*Please provide documents to prove authority to sign on behalf of the patient.]

Revised 4/8/2025