Hudson's Bay Medical Group Inc. P.S.

100 E 33rd St, Ste. 206A
Vancouver, WA 98663
Phone (360) 695-1334,
Fax: (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:

☐ Past 2 Years of Health Records

OR, if looking for specific information:

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

***** Incoming Records:** If page count is greater than 75 pages, please send Secure Email to lissette@hudsonsbaymed.com

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
  _____HIV/AIDS diagnosis/treatment/testing
  _____Genetic Testing
  _____Sexually Transmitted Infections
  _____Mental Illness or Psychiatric diagnosis/treatment
- 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 03/17/2026