REQUESTING RECORDS

Authorization For My Healthcare Information to be Used or Disclosed to:

Dr. Jean R. Dydell
Dr. Chelsea Price
Dr. Mary T. Tsuang
Dr. Christina Tun
12303 N.E. 130th Lane Suite #230, Kirkland, WA 98034
425-899-5000 (phone) 425-899-5006 (fax)

Patient Name: _____ **Date of Birth:** _____

Previous Name: _____

I. My Authorization

You may use or disclose the following healthcare information (check all that apply):

__ All healthcare information in my medical record.
__ Healthcare information in my medical record relating to the following treatment or condition:
_____
__ Healthcare information in my medical record for the date(s): _____
__ Other (e.g., X-rays, bills), specify date(s): _____

You may use or disclose healthcare information regarding testing, diagnosis, and treatment for (check all that apply):

__ HIV (AIDS)
__ Sexually transmitted diseases
__ Psychiatric disorders/mental health
__ Drug and/or alcohol use

Healthcare information to be disclosed from:

Name (or title) and organization: _____
Address: _____ City:_____ State: ___ Zip: _____
Phone: _____ Fax: _____

Reason(s) for this authorization (check all that apply):

__ at my request
__ check only if (practice/facility) requests the authorization for marketing purposes
__ other (specify) _____
__ check only if (practice/facility) will be paid or get something of value for providing health information for marketing purposes

This authorization does not permit disclosure of health information created more than:

__ in 90 days from the date signed
__ on (date): _____
__ when the following event occurs: _____
(no longer than 90 days from date signed)

II. 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 a research study or
- To receive healthcare when the purpose is to create healthcare information for a third party

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by, Eastside OB/GYN 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 Eastside OB/GYN, or
- Write a letter to your doctor

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

_____ _____ _____
Patient or legally authorized individual signature | Date | Time

_____ _____
Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative)

PRINT RESET