SKAGIT Family HEALTH CLINIC

916 South 3rd Street
Mt. Vernon, WA 98273-4324
Voice: (360) 336-5658
Fax: (360) 336-5655
www.skagitfamilyhealth.com

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

Date Recd:
Date Sent:

I Hereby Authorize:

- ❑ Facility Name: _____ Doctor's Name: _____
  Address: _____
  City: _____ State: _____ Zip: _____
  Phone #: _____ Fax #: _____

From the Health Records of:

Patient Name: _____ Date of Birth: _____
Social Security #: _____ Daytime Phone: _____
Are you authorizing release of your own records? ☐ Yes ☐ No
If not, what is your relationship to the patient? _____

To Release:

- ❑ Complete Chart Record **(Will be limited to the last 3 years of information unless otherwise stated, does not include billing information or radiographic images)**
- ❑ Chart Notes: ☐ All ☐ Specify: _____
- ❑ Labs/Imaging Reports **(No chart notes needed)** ☐ All ☐Specify: _____
- ❑ Other (Billing records, X-Ray/Images, etc.):_____

To Be Released To:

- ❑ Skagit Family Health Clinic, LLC
- ❑ Self (please provide address below, **copy charges may apply**)
- ❑ Facility Name: _____ Doctor's Name: _____
  Address: _____
  City: _____ State: _____ Zip: _____
  Phone #: _____ Fax #: _____

For The Purpose Of:

- ❑ Adjunctive/Concurrent Care
- ❑ Transfer of Care
- ❑ Other: _____

*The following items **will be included** in records unless initialed.
*HIV/AIDS/STD-related records_____
*Mental Health information_____
*Genetic testing information_____
*Drug/alcohol abuse/dependency diagnosis, treatment, or referral information_____

This authorization is valid for ninety (90) days from the date signed. I can cancel this authorization at any time by writing to SFHC unless disclosure has already occurred in compliance with this consent. I understand that authorizing the disclosure of this health information is voluntary. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws, and may potentially be re-disclosed by the recipient. I can refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment.

Patient/Guardian Signature:_____ **Date:**_____