# Medical Records Release Form

Patient name: _____ Date of birth: _____

Social Security #: _____ Phone: _____

***Please circle where the records are coming "FROM" and where they are being released "TO"***

| To | From | To | From |
|---|---|---|---|
| Skagit Family Health Clinic<br>916 S. 3rd Street<br>Mount Vernon, WA 98273 | | Name of Physician or Facility:<br>_____<br>Address: | |
| Phone: 360-336-5658 | | Phone: | |
| Fax: 360-336-5655 | | Fax: | |

**To Release:**

- ☐ All health care information (will be limited to the last 3 years unless otherwise stated)
- ☐ Labs & Image reports only
- ☐ Only these records (specify): _____
- ☐ Only records dated from: _____ to _____

**For The Purpose Of:**

- ☐ Adjunctive/Concurrent Care
- ☐ Transfer 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: _____

Relationship to Patient: _____