THE POLYCLINIC
Where you come first.

Authorization to Release Medical Records:

PATIENT INFORMATION:

Name (Print) **Please include maiden or other name if applicable.* DOB SSN

_____ _____ _____

INFORMATION TO BE RELEASED FROM:

Name of facility or provider

_____

Address

_____

INFORMATION TO BE SENT TO:

Name of designated recipient

_____ Fax Number: _____

Address City State Zip

_____ _____ _____ _____

Release to active my chart account: Yes _____ No_____ Initials _____

INFORMATION TO BE RELEASED: (check one)

_____ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
_____ All medical records
_____ Specific information (please specify) :

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)

_____ Attorney _____ Insurance _____ Doctor _____ Personal

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

* EXCLUDE the following information from the records released (please initial)

_____ Drug / Alcohol abuse/treatment & diagnosis _____ Sexually transmitted disease
_____ HIV/AIDS diagnosis/treatment/testing _____ Mental illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____
(Patient, guardian*, or Authorized representative*)

***Note: Requests can take up to 15 business days to process. Please indicate urgency when necessary.**

This authorization will expire 90 days from the date signed
Possible copying fee required

Please fax this completed form to: 1-920-593-3029 or mail to: The Polyclinic ROI Department, 1145 Broadway, Seattle WA, 98122

If you have questions regarding your request, please call: 1-920-784-2482 (please allow 48 hours for your request to be received and entered into our system before calling)