Account # _____

ASSOCIATED VALLEY OBSTETRICS AND GYNECOLOGY
4011 Talbot Road South, Suite #430
Renton, WA 98055
(425) 656-2496 fax (425) 572-6150

Authorization for Associated Valley Obstetrics and Gynecology to Use or Disclose My Health Care Information

Patient's Name _____
Please Print Last First MI
Previous Name(s) _____Birth date ____/____/____
Social Security # _____-_____-_____ Phone Number (_____) _____
Address _____ City _____ State _____ Zip Code _____

I hereby authorize:

Assoc. Valley Ob/Gyn
4011 Talbot Rd S, #430
Renton, WA 98055

to release a copy of my medical records to:

Name (Doctor or Clinic) _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

***If you'd like to have the records emailed securely, please give email: _____**

○ **Dr. Channell** ○ **Dr. Kovacs** ○ **Dr. Martin** ***Please check here if you want records on a CD: _____**
○ **Dr. Lewis** ○ **Dr. Hunt** ○ **Dr. Hamer**

Please send the following information concerning my care in your office:

○ **OB records** ○ **Most recent lab work**
○ **All health care information in my medical record** ○ **Other_____**

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS), sexually transmitted diseases, psychiatric disorders, mental heath or drug and/ or alcohol use, you are specifically authorized to release all heath care information relating to such diagnosis, testing, and / or treatment.

MY RIGHTS:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- **To take part in a research study or**
- **To receive health care when the purpose is to create health care information for a third party.**

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Associated Valley Obstetrics and Gynecology based upon this authorization and 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 The Practice. Or**
- **Write a letter to the Practice**

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

_____ Date _____
Patient or legally authorized individual signature

_____ _____
Printed name Relationship

This authorization expires 90 days after the date it is signed. **Sent _____**