

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 Birth date ____/____/____
Previous Name(s) _____
Social Security # _____ - _____ - _____ Phone Number (____) _____
Address _____ City _____ State _____ Zip Code _____

I hereby authorize: _____ to release a copy of my medical records to:
Name (Doctor or Clinic) _____ Assoc. Valley Ob/Gyn
Address _____ 4011 Talbot Rd S, #430
Renton, WA 98055
City/State/Zip _____
Phone _____ Fax _____

- Dr. Channell Dr. Kovacs Dr. Martin
- Dr. Lewis Dr. Hamer Dr. Hunt

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 _____

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.

* **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 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.

Patient or legally authorized individual signature Date _____

Printed name Relationship
This authorization expires 90 days after the date it is signed. Sent _____