Account # ________________

**ASSOCIATED VALLEY OBSTETRICS AND GYNECOLOGY**
**4011 Talbot Road South, Suite #430**
**Renton, WA 98055**
**Ph: (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:** **to release a copy of my medical records to:**

**Name (Doctor or Clinic)** ________________________________

**Address** ________________________________

**City/State/Zip** ________________________________

**Phone** ____________________ **Fax** ____________________

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

○ Dr. Channell ○ Dr. Martin ○ Dr. Tolley
○ 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.

________________________________ **Date** ______________
**Patient or legally authorized individual signature**

________________________________ ________________________
**Printed name** **Relationship**
**This authorization expires 90 days after the date it is signed.** **Sent** __________