

AUTHORIZATION FOR:
Emerald City Medical Arts
16 Roy Street
Seattle, WA 98109
Fax 206-282-7371

To Use or Disclose My Health Care Information To:

Facility Name: _____

Address: _____

City: _____ State: _____ Zip _____

Telephone: (____) _____

My Authorization

You may use or disclose the following health care information (check all that apply):

- All records pertaining to _____
- All medical records in your possession concerning health, illness and/or treatment.
- Recent lab test only Immunization records only.
- Diagnostic Studies (Labs, X-ray, EKG, etc.)

Patient Name: _____
(Last, First, Middle)

Previous Name: _____
(Last, First, Middle)

Address: _____

City: _____ State: _____ Zip _____

Telephone: (____) _____ Social Sec. # ____--____--____ DOB: ____/____/____

If requesting birth records, include mother's name at time of birth: _____

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS or HIV Infection, alcohol and/or drug abuse and mental health conditions.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization expires in 90 days.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.

I understand that except in limited circumstances, such as research-related treatment or treatment that is solely for the purpose of disclosing health information to a third party, I am not required to sign this authorization in order to receive treatment.

The facility, its employees, officers, agents and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: _____
(Patient)

Date: _____

(or Legal Representative and Relationship)

Date: _____