*ONLY PROPERLY COMPLETED FORMS WILL BE PROCESSED*

## AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION TO ANOTHER PROVIDER, OFFICE, OR THIRD PARTY

Phone 425-454-3356 * Fax 425-646-5198
Bellevue 1800 116th Ave. NE, Suite 201, Bellevue, WA 98004
Issaquah 751 NE Blakely Dr., Suite 2030, Issaquah, WA 98029

Your Name:______________________________________________________________________________

Your Address:____________________________________________________________________________

City/State/ZIP:_____________________________________________Telephone:_________________________

Your date of birth:_____________________________Your OOBGYN Provider:____________________________

**Charges may apply. Please see page 2 information and initial here: Initials:_______________**

### Overlake OBGYN request of records to be sent out

**I request and authorize Overlake OBGYN to release information to:**

Provider or Organization:_______________________________________________________________

Clinic Address:_______________________________________________________________________

Clinic City/State/Zip:__________________________________________________________________

Clinic Phone:__________________________Fax:__________________________________________

### Overlake OBGYN authorization to receive records

**I request and authorize the provider/clinic indicated below to release health information to Overlake OBGYN.**

Provider or Organization:_______________________________________________________________

Clinic Address:_______________________________________________________________________

Clinic City/State/Zip:__________________________________________________________________

Clinic Phone:__________________________Fax:__________________________________________

I UNDERSTAND THAT:

- Authorizing the disclosure of the health information is voluntary. I do not need to sign this from in order to assure treatment or payment
- I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to OOBGYN. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Unless I specify differently, this authorization will expire 12 months or one year from the date of signature below.
- Once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Information to be disclosed is indicated by checked box and is for the following dates of service:______________________________

- ☐ All/Entire Record
- ☐ Consults
- ☐ Hospital Records
- ☐ History & Physical
- ☐ Lab Results
- ☐ Mammography/Radiology
- ☐ Medication List-Current
- ☐ Pathology Report
- ☐ Progress Notes/Visit Notes
- ☐ HIV Information
- ☐ Sexually Transmitted Diseases
- ☐ Genetic Records
- ☐ Substance Abuse

OTHER________________________________

### AUTHORIZATION/SIGNATURES

Date:______________________Patient/Guardian Signature:_____________________________________________

**RELEASE OF RECORDS MAY TAKE UP TO 15 WORKING DAYS.**
**OVERLAKE OBGYN WILL ONLY PROCESS VALID AND COMPLETE AUTHORIZATION FORMS**

**Where to send completed form:**

- If you complete this form at OOBGYN you may give it to a clinic staff member
- If you are completing this form at home, you may mail or fax to:

Overlake OBGYN
Attn: Medical Records Department-ROI
1800 116th Ave., NE, Suite 201
Bellevue, WA 98004

**Or fax** to 425-646-5198

**Where to call with questions:**
To check status on a request, please call 425-454-3366

**Fee for coping medical records**
If you are requesting a copy for your personal use, a fee will be charged (see fee schedule below). Charges for the copies are in compliance with the Washington Administrative Code (WAC 246-08-400).

- 0-10 pages, no charge
- If more than 10 pages, 0-30 pages $1.04 per page
- Over 30 pages, $0.79 per page

**Mental Health Information**
State law (RCW 71.05039) prohibits any further disclosure (re-disclosure) of mental health information without specific written consent of the person, to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by state law. A general authorization to release information is NOT sufficient for this purpose.

**Consent of A Minor** (RCW 70.96A.230, RCW 70.96A.235, RCW 70.96A.095)
A minor patient's signature is required on the patient signature line to release the following information only:

1) Conditions relating to productive care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS (age 14 and older): and
2) Substance abuse diagnosis or treatment and mental health conditions (age 13 and older).

A parent or legal guardian signature is required for the release of all other healthcare information for minors.

**PROHIBITION ON RE-DISCLOSURE OF HEALTH INFORMATION**

Federal and state laws prohibit re-disclosure of information concerning drugs or alcohol abuse treatment, sexually transmitted disease information or mental health information without the specific written consent of the person to whom the information pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.