Overlake
Obstetricians & Gynecologists, PC

ONLY PROPERLY COMPLETED FORMS WILL BE PROCESSED

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

Phone 425-454-3366 * Fax 425-658-5134* Email medical.records@overlakeobgyn.com

1231 116th Ave. NE # 950, Bellevue, WA 98004

PATIENT NAME: _____
Last First Middle Maiden

TELEPHONE NUMBER: _____ BIRTHDATE: _____

Information to be released **FROM**: _____

Address _____
City, State, Zip Code

Phone Number _____ Fax Number _____

Information to be released **TO**: _____

Address _____
City, State, Zip Code

Phone Number _____ Fax Number _____

PURPOSE OF RELEASE:
[ ] Transferring Care
[ ] Moving Out of the Area
[ ] Health Insurance Change
[ ] Appointment with a Specialist
[ ] Continuing Care with PCP
[ ] Personal/Other_____

INFORMATION TO BE RELEASED:*
[ ] the most recent 2 years of pertinent information
[ ] All Medical Records
[ ] Specific information :(Please Specify) _____
_____
_____

Patient Authorization:

This authorization includes records that **MAY CONTAIN** information regarding the diagnosis or treatment of **HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment.** *Please initial if you wish to **exclude** these records.*_____

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.

AUTHORIZATION/SIGNATURES

Date:_____ Patient/Guardian Signature:_____