Account # _____

ASSOCIATED VALLEY OBSTETRICS AND GYNECOLOGY
4011 Talbot Road South, Suite #430
Renton, WA 98055
(425) 656-2496 fax (206) 575-2616

Authorization for Associated Valley Obstetrics and Gynecology to Use or Disclose My Heath 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:

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

to release a copy of my medical records to:

Name _____ **Phone** _____

Address _____

City/State/Zip _____

○ Dr. Hanlon ○ Dr. Keegan ○ Dr. Oxford
○ Dr. Webb ○ Dr. Channell ○ Dr. Cole

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** _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS), sexually transmitted diseases, psychiatric disorders, mental heath or drug and/ or alcohol use, you are specifically authorized to release all heath care information relating to such diagnosis, testing, and / or 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** _____