OBSTETRIX MEDICAL GROUP
Obstetrix Medical Group, at Issaquah
Ph 425.394.5021 · Fax 425-391.1883

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____ to disclose information
(Name of Healthcare Provider / Organization / Clinic)

from the health records of: **Patient Name:** _____
Last Name First Name Middle Name

(Previous Name, if applicable): _____

Address _____ City/State _____ Zip _____

Hm phone (_____) _____ Cell (_____) _____ Soc Sec No. _____

Date of birth _____ Date(s) of Medical Care _____

[ ] Send To: Attn: _____
Obstetrix Medical Group, Issaquah
751 NE Blakely Drive, Suite 2030
Issaquah, WA 98029
Ph 425.394.5021 ▪ Fax 425.391.1883

[ ] Send To: Attn: _____
Address: _____
_____
City/St/Zip: _____
Ph/Fax: _____

Information to be disclosed:

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Diagnostic Studies (labs, x-ray, EKG, etc.)
- ☐ Progress (Chart) Notes
- ☐ Emergency Department Report
- ☐ **Other:** _____

For the purpose of: _____

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

NOTES: _____

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 disease, 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 other 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.

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

I understand that except for 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 at Obstetrix Medical Group, at Issaquah.

Patient signature _____ Date _____

Authorized Legal Representative _____ Relationship _____