<u>AUTHORIZATION FOR RELEASE OF INFORMATION</u>

Patient Information (please print):

____

Name DOB SSN

Information to be released from:

____

Name of designated facility or provider

____

Address

I request and authorize Lake Burien Physical Therapy or the provider named above to release health care information of the patient named above to:

____

Name of designated recipient

____

Address

____(_______)__________________

City, State, Zip Phone Number

Information to be Released:

☐ All medical records ☐ All Medical Billing Records

☐ Specific information (please specify): ____

Purpose for which disclosure is being made (please circle one of the following):

Attorney Insurance Doctor Personal

Patient Authorization: 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 one of the aforementioned, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

My Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may disclose it, at which time it may no longer be protected under Privacy laws.

Reasonable Fee: State law provides that a health care provider may charge a reasonable fee.

____ ________________

Signature of Patient or Patient's Authorized Representative Date Signed

This authorization will expire 90 days from the date signed.