Overlake Reproductive Health

AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS AND INFORMATION

I, _____ Birthdate: ___/_____/_____

Authorize **OVERLAKE REPRODUCTIVE HEALTH, Inc., P.S.** release records to:

_____
(Person/Facility)

_____
Street Address City/State Zip

_____
Phone # Fax #

The following information:

Please indicate the year that you were last seen by Overlake Reproductive Health: _____

Personal health records during the period of: _____

_____ All medical records Chart #: _____
_____ Lab results
_____ X-ray results X-ray#: _____
_____ Original x-rays*

*any original X-rays so released will be promptly returned as soon as possible if necessary.

This consent _____ INCLUDES _____ EXCLUDES Release of information pertaining to (check in each area):
_____ INCLUDES _____ EXCLUDES Drug or alcohol abuse diagnosis or treatment
_____ INCLUDES _____ EXCLUDES HIV (AIDS) testing/treatment
_____ INCLUDES _____ EXCLUDES Psychiatric care/mental illness
_____ INCLUDES _____ EXCLUDES Confirmed STD test results and/or treatment

I understand that records are protected under confidentiality regulations, and any records that contain information regarding drug and/or alcohol abuse that are created by an alcohol abuse or drug abuse prevention program are protected under federal confidentiality laws (42 CFR Part 2) and state law. I understand that said records containing information about the diagnosis, treatment, or referral of alcohol and drug abuse problems cannot be disclosed without my written consent, and that those receiving this information are prohibited from re-disclosing these records unless expressly permitted by my written consent. I understand that any records that contain information regarding HIV and or confirmed STD tests or treatment are protected by state confidentiality laws (RCW 70.24). I understand that and HIV and/or confirmed STD tests or treatment records cannot be disclosed without my written consent unless permitted by State law, and that those receiving this information are prohibited from re-disclosing these records without my further written consent.

This consent may be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

_____ _____
Signature Print Name

_____ _____
Witnessed Date