Care Medical Group

Medical Record Release Authorization

Patient Name: _____ Date of Birth: _____
(First Name Middle Initial Last Name) (mm/dd/yyyy)

Previous Name: _____ Phone: (___) _____
Area

Information to be released from:

Name: _____ Organization: _____

Address: _____ City: _____ State: _____

Zip code: _____ Phone: (___) _____ Fax: (___) _____

Information to be sent to:

Name: _____ Organization: _____

Address: _____ City: _____ State: _____

Zip code: _____ Phone: (___) _____ Fax: (___) _____

The entity named above may disclose the following health care information to the designated recipient (*at least one box must be checked to process request*):

☐ **ALL** health care information in my medical record. This includes treatment regarding HIV/AIDS, sexually transmitted diseases, mental health disorders, drug and/or alcohol use if previously treated or currently under treatment, and medical records previously received from other entities, including provider facilities and insurance companies.
☐ Only health care information in my medical record relating to the following condition:

_____

☐ Health care information in my medical record for the date(s): _____

☐ Other (please be specific and list specific dates): _____

I request that the following information will be excluded from this release (*at least one box must be checked to process request*):

☐ No exclusions requested
☐ HIV/AIDS related treatment information
☐ Sexually transmitted diseases
☐ Mental health treatment
☐ Drug and/or Alcohol use
☐ Reproductive care (minors only*)
☐ Other (be very specific): _____

4280 Meridian St Ste 120 Bellingham, WA 98226 | Phone: (360) 734.4300 | Fax: (360) 734.2128

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I understand that the following fees* apply and require payment prior to record release:

$1.02 per page for pages 1 – 30 (does not apply for personal requests)
$0.78 per page for pages 31 and after (does not apply for personal requests)
$25.00 per x-ray CD

I understand that this is an authorization for release of my medical record in the manner stated on this release. This is not an authorization for treatment, payment of treatment or for any other type of health care benefits.

This authorization to release medical records expires (*one box must be checked to process request*):

☐ on (specific date): _____
☐ once this request has been completed
☐ 90 days from the dated signature below

By signing below, I authorize Care Medical Group to execute this medical record release. I may revoke this authorization in writing at any time. If I elect to revoke this authorization, it does not effect any actions already taken by Care Medical Group by my authorization. To revoke this authorization, I agree to fill out the Medical Record Request Revocation form available from Care Medical Group or I will provide in writing to Care Medical Group, the details of my revocation. Once my health care information is released, the entity I authorized Care Medical Group to release information to may re-disclose the information and privacy laws may no longer govern it use and/or disclosure.

Signature: _____ Date: _____
(Full signature by patient or legal patient representative) (mm/dd/yyyy)

Print Name: _____ Relation: _____
(First Name Middle Initial Last Name) (i.e. self, legal guardian)

*Fees: Fees are determined by Washington State legislation under WAC 246-08-400, RCW 70.02.0 and in accordance with HIPAA 164.524 (c)(4)
***Minors:** A minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

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