MERIDIAN MEDICINE
2111 N. Northgate Way #201   Seattle, WA 98133
Ph# 206-525-8015 / Fax# 206-525-8014

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

I HEREBY AUTHORIZE:

Meridian Medicine ______________

Outside Facility/Doctor's Name____

Address: ____

City: ______________________________________ State: ___________ Zip: ________________

Phone: __________________________________ Fax: __________________________________

TO RELEASE:

PLEASE MAIL OR FAX HARD COPIES – WE DO NOT ACCEPT RECORDS VIA CD or EMAIL

- Complete Chart Record – Does not include billing/radiographic images: ________________
- Chart Notes: ALL / Specify date range: ____
- Labs/Reports: ALL / Specify date range: ____
- Billing Records: ALL / Specify date range: ____
- X-ray/Radiographic Images: Specify:____
- OTHER: ____

FROM THE HEALTH RECORD OF:

Name: ____

Date of Birth: ____________________________Daytime Phone: __________________________________

Are you authorizing the release of your own records? YES___________ NO _____________

Release of certain medical information requires a minor's consent. This applies to person's aged 13-17 for information pertaining to substance abuse, mental health, or sexually transmitted diseases, HIV, and AIDS. Other laws may apply.

TO BE RELEASED TO:

Meridian Medicine __________________ Self (Additional Charges may apply): ________________

Outside Facility/Doctor:____

Address: ____

City: ______________________________________ State: _______________ Zip: _____________

Phone: _____________________________________ Fax: ___________________________________

FOR THE PURPOSE OF:

Adjunctive/Concurrent Care: ___________ Transfer of Care: _________ Other: ______________________

I understand that unless revoked this authorization is valid for 90 days from date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document. ***Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis, and treatment information related to: (check all that apply)***

Substance Abuse_____Mental Health______ Sexually Transmitted Diseases______ HIV/AIDS_____

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my information it may be re-disclosed and may not be protected. I understand that I do not have to sign this form as a condition of receiving treatment and that I am entitled to a copy of this authorization form at the time of signing.

Patient's Name (PRINT) _______________________Patient's Signature _________________________________

Guardian Name (PRINT) ______________________Guardian Signature _________________________________

Relationship to Patient _____________________________________ Date ___________________________________

Revised 7/2018