Rebel Med Northwest
5401 Leary Ave NW STE 202
Seattle, WA 98107
Phone: (206) 297-6013; Fax: (206) 582-3472

OFFICE ONLY: Date Rec'd: ____/____/____
Date Sent:: ____/____/____

Authorization to Release Confidential Health Information

I Hereby Authorize:

❑ Rebel Med Northwest
❑ Facility/Doctor's Name: _____
Address: _____
City: _____ State: _____ Zip: _____-_____
Phone #: _____ Fax #: _____

To Release:

❑ Complete Chart Record *(does not include billing information or radiographic images)*
❑ Chart Notes: ❑All ❑Specify: _____
❑ Labs/Reports: ❑All ❑Specify: _____
❑ Billing Records: ❑All ❑Specify: _____
❑ X-rays/Radiographic Images(specify): _____
❑ Other:_____

From the Health Records of:

Name: _____ Date of Birth: _____/_____/_____
Soc. Sec. Number: _____ Daytime Phone: _____ ext:: _____

Are you authorizing release of your own records? ❑Yes ❑No
If not, what is your relationship to the patient?_____

Release of certain medical information requires a minor's consent. This applies to persons aged 13 to 17 for information pertaining to substance abuse and mental health information, or persons aged 14 to 17 for information pertaining to sexually transmitted diseases, HIV and AIDS. Other laws may apply.

To be Released to:

❑ Rebel Med Northwest: _____ ❑Self (provide current address below) **^fee may apply**
❑ Facility/Doctor's Name: _____
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 the 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.**

(check the accompanying box(s) below to EXCLUDE the information from authorization)

❑ substance abuse ❑ mental health conditions/psychotherapy ❑ sexually transmitted diseases and ❑ HIV/AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.

I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing. I may call the office at (206) 297-6013 to inquire about revoking authorization.

I understand that if I request records for personal use, to hand-carry to another health provider, or for parties not involved in my health care, there may be a charge. 'Non-emergency' release of records may take up to 15 working days. Emergency requests for the release of medical records to another healthcare provider will be given priority processing.

Patient's Signature: _____ Date: _____

Rep./Guardian's Signature: _____ Date: _____