Allcare Medical Clinic
148 Park Avenue N. Renton, Washington 98057
Phone: (425) 255-0055 Fax: (425) 255-9501

RECORDS RELEASE FORM*

Patient Information: Print Name _____Date of Birth_____

SS# _____Maiden or Prior Name_____

Please Release my records From:	**Please Send my healthcare information TO:**
Name of Facility or Provider:	Name of designated Recipient:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone #	Phone #
Fax #	Fax #

Information to be released:
( ) Specific information related to my_ _____
( ) All clinical records for most recent 2 years (chart notes, labs/radiology reports, specialists' consults)
( ) All my clinical records in the chart. (This will exclude old records (if any) rec'd from other providers, billing records etc unless requested by the party)

Purpose for which disclosure is being made:
( ) Health care ( ) Personal use ( ) Legal purpose
( ) Other_____

Patient Authorization:
I authorize the release of my health care information as requested above. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immuno-deficiency syndrome (AIDS), human immunodeficiency virus (HIV test), evaluation/treatment for behavioral/mental health services or for alcohol and/or drug use/abuse. I specifically authorize to release all health care information relating to such diagnosis, testing or treatment. Please check the boxes below if you do not want to release such information.

Please **DO NOT** release information on the following (unless required by law)
( ) HIV/AIDS ( ) Sexually transmitted diseases ( ) Psychiatric treatment records ( ) Drug and/or alcohol treatment

My Rights:
I understand that 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 kept/posted at the facility where your information is begin released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

Fees for copying health records;
ALLCARE Medical clinic will continue to provide one complementary copy of the patient's medical record to another health care provider when requested. (exceptions: emergency situations)

However, copies of medical records requested by patients or other parties are not free. Our charges **(subject to change without notice)** are as follow: $19 fee for searching for and handling records, 85 cents per page for the first 30 pages copied and 65 cents for each additional page after. (These fees are subject to change without notice) I under stand that all fees must be paid in full prior to releasing the records.

I also understand that I may be charged at the rates shown above for the copies for the records I have requested and for postage (if applicable). I agree to pay the total charges prior to receipt of the copies.

Signature:_____ Relation w/ pt: _____Date:_____
(Patient, guardian or authorized representative)

This authorization will expire 90 days from the date signed.

* Authorization for release of records, Rev 12-20