

Dr. Candace Asan
Dr. Anna Evershed
Dr. Cate Berezney
12911 - 120th Ave NE, Ste E-50, Kirkland, WA 98034
Phone: 425-820-7700 • Fax: 425-820-7707



AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ DOB: _____

I request and authorize _____ Fax: _____

Address: _____ Tel: _____

to release health care information of the patient named above to:

<input type="checkbox"/> Dr. Candace Asan <input type="checkbox"/> Dr. Anna Evershed <input type="checkbox"/> Dr. Cate Berezney 12911 - 120 th Ave NE, Suite E-50 Kirkland, WA 98034	<input type="checkbox"/> Other Name: _____ Address: _____ Tel: _____ Fax: _____
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Information to be released:

- Vaccination records and growth charts
 Health care information (last 3 years) _____ office visits _____ Labs _____ Imaging
 Last wellness visit, vaccination records, growth charts
 Other: _____

Purpose for disclosure:

____ Attorney ____ Insurance ____ Doctor ____ Personal ____ School

Patient Authorization:

I understand that my specific consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorder/mental health conditions, or drug and/or alcohol use. I am specifically authorizing the release of all health care information relating to such diagnosis, testing, or treatment.

EXCLUDE the following information from the records released (please initial):

____ Substance abuse _____ Sexually transmitted diseases
____ HIV/AIDS diagnosis/treatment/testing _____ Mental health conditions/treatment

Patient rights:

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. 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. **I understand that if I request records for personal use, to hand-carry to another healthcare provider, or for parties not involved in my healthcare, there will be a \$25 charge. All records requests will be processed within 5 business days.**

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Relationship to patient: _____