Chris Brubaker, MD, PhD
Comprehensive Psychiatry for All Ages

927 North Northlake Way, Suite 120
Seattle, WA 98103
Phone: 206-486-4993

RELEASE OF INFORMATION AGREEMENT

Patient Name: ____ Date of Birth: ______________

- I agree to allow Dr. Christopher Brubaker to discuss my care and treatment with, and/or to release any medical records related to my care and treatment to, the individual or organization listed below.
- I also authorize the individual or organization listed below to discuss my care and treatment with Dr. Brubaker, and/or to release any medical records related to my care and treatment to him. This will serve as my written request to the individual or organization listed below that they release said information to Dr. Brubaker.
- I understand that this agreement allows the release of records and/or discussion of material pertaining to all medical and psychiatric care, including HIV status and alcohol/drug use.

Individual / Organization Name	
Relationship to Patient	
Phone Number	
Fax Number	
Address	
Purpose of Request	☐ Coordination of Care ☐ Transfer of Care ☐ Other
Records to be Obtained	☐ Coordination of Care ☐ Transfer of Care ☐ Laboratory Results ☐ Discharge Summaries ☐ Other:
Records for Dates:	No restrictions *or* ______________ to ______________

This agreement will remain in force until I request that it be revoked, or until 90 days after termination of care.

____ ______________
PATIENT SIGNATURE DATE

____
PATIENT NAME (PRINTED)