NORTHWEST WOMEN'S HEALTHCARE

Authorization To Release Health Information

Patient Name: _____
LAST FIRST M.I.

Birth Date (MM/DD/YYYY): ____/____/____ Phone Number: _____

INFORMATION TO BE RELEASED FROM:	INFORMATION TO BE RELEASED TO:
Organization/Person Name	Organization/Person Name
Street Address	Street Address
City, State, Zip	City, State, Zip
Phone Fax	Phone Fax

TYPE OF MEDICAL INFORMATION TO BE RELEASED:

- ☐ Last two years of health information only.
- ☐ Health information related to the following treatment/condition: _____
- ☐ Health information for the following dates: _____

REASON FOR REQUEST: ☐ Transfer of Care ☐ Continuing Care ☐ Personal

This authorization, unless expressly limited by me in writing, will extend to all aspects of testing and/or treatment of STDs, HIV, alcohol and/or drug abuse, mental health conditions or other sensitive information. Minors must sign the request themselves if information requested includes treatment for drug/alcohol abuse, mental health conditions or conditions related to reproductive care and sexual history to include contraception, pregnancy, pregnancy termination, sterilization and STDs.
This authorization expires 90 days from the date signed.

_____ _____
Patient Signature Date

_____
Relationship to patient if signed by anyone other than patient (i.e. parent, legal guardian, personal representative, etc.)

Mail or fax requests to:
Northwest Women's Healthcare
1101 Madison Street, Ste. 1150 | Seattle, WA 98104
Fax: 206-386-3411

nwwomenshealth.com | 206.386.3400