AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name: ______________________ , ____________________ ___ Date of Birth: ___/___/______

I authorize:

Upton Family Medicine

221 4th Ave North

Edmonds, WA 98020

To release health information to:

Name:

Address:

Phone:

Fax:

Please specify the health information you authorize to be released:

Type(s) of health information: ____

Specify date(s): Unless noted, most recent 2 years will be provided. Exception requested for time period ____________ to _____________.

Please describe the purpose of this release: ______________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS/HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby specifically authorized to release all information or medical records relating to such diagnosis, testing or treatment, unless specifically excluded here.

____

I understand I do not need to sign this form in order to assure treatment or payment.

Unless otherwise revoked, this Authorization expires on ________. If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

Please read the important notice concerning your rights on the following page.

Signature:

______________________	______________________	______________________
Signature (Patient, Parent, Guardian)	Print Name	Date Time
______________________	______________________	______________________
Relationship to Patient (Parent/Guardian/	Witness (if patient unable to sign)	Phone Number