



**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Patient's name \_\_\_\_\_ Date of birth \_\_\_\_\_

SSN \_\_\_\_\_ Previous name \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_

Zip code \_\_\_\_\_ Phone number \_\_\_\_\_

**I. My Authorization**

**You may use or disclose the following health care information (check all that apply)**

- Core Chart (see back instructions)
- All health care information in my medical record
- Only health care information in my medical record relating to the following treatment or condition:  
 \_\_\_\_\_ Dates \_\_\_\_\_

Other (e.g., X rays, bills) specify: \_\_\_\_\_ Dates: \_\_\_\_\_

Please **DO NOT** release information on the following (unless required by law)

- HIV (AIDS virus)  Psychiatric disorders/mental health
- Sexually transmitted diseases  Drug and/or alcohol use

**I request and authorize:**

Name: \_\_\_\_\_ Address \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City/State/ZIP \_\_\_\_\_

**Purpose or need for this information** \_\_\_\_\_

**II. My rights**

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I may revoke this authorization in writing. If I did it would not affect any actions already taken by Minor and James Medical based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I must write a letter to Minor and James Medical records release department.

This authorization expires 90 days after the date it is signed. Please read the information on the back and initial the appropriate blank before signing. Possible copying fee required, excludes patient referrals.

\_\_\_\_\_  
Patient or legally authorized individual signature Date

\_\_\_\_\_  
Printed name if signed on behalf of the patient

**NOTICE**

**Minor and James** keeps a record of the health care services provided to you. You may ask to examine and / or request a copy of your records. You may also ask to correct that record. Your records will not be released to others unless directed by you or compelled by law to do so. You may examine your records or get information about them at:

**Minor & James Medical**

**515 Minor Ave., Suite 200  
Seattle, WA 98104  
(206) 386-9500**

**Minor and James** has contracted with **Secure Health** to do all copying and billing for release of information requests. The following information will be released to you or your new medical care provider at no charge:

**CORE CHART (Up to 15 pages)**

- The three most recent Chart Notes.
- The most recent History & Physical.
- The most recent Lab Tests.
- The most recent Radiology Reports.
- The most recent EKG Report.
- The most recent Problem List.
- The most recent Medication List.
- Any recent Special Tests or Reports.

The above information is considered sufficient for continuity of care treatment. Due to the time and cost involved in reproducing this information, if you would like all of your records released, then you will be charged at the rates set by the State of Washington (see below). If you do request this information, you will be contacted by **Secure Health** to arrange payment.

The schedule of charges below is created and regulated by the Washington State Uniform Health Care Information Act, RCW 70.02, Section 102 (12), and an authorization does not have to be honored until the fee is paid:

**\$21.00 Clerical / Search fee**  
**\$ .91 Per page for the first 30 pages**  
**\$ .69 Per page for additional pages over 30 pages**  
**Postage or Delivery—Actual Cost**  
**Applicable Washington State Sales Tax**

**Please initial one of the following:**

\_\_\_\_\_ I wish to have the Core Chart copied at no cost.

\_\_\_\_\_ I wish to have my whole chart copied at the above cost.