BASTYR CLINICAL RESEARCH CENTER
Medical Records
14500 Juanita Dr NE; Kenmore, WA 98028
Phone: (425) 602-3311; Fax: (425) 602-3420

OFFICE ONLY: Date Rec'd: ____/____/____
Date Sent: ____/____/____
Practitioner: ________________________________

Authorization to Release Confidential Health Information

(*Practitioners initials are required for release of records to patients or non-healthcare providers.)

* I Hereby Authorize:

❑ Bastyr Clinical Research Center *** = required information**

* To Release:

❑ Chart Notes: ❑All ❑Specify: ________________________________
❑ Labs/Reports: ❑All ❑Specify: ________________________________
❑ xray/Radiographic Reports: ❑All ❑Specify: ________________________________
❑Chemotherapy Summary/Notes:________________________________
❑ Doctors' Summary Notes:________________________________

From the Health Records of:

*** = required information**
*Name: ________________________________*Date of Birth: _____/_____/_____
*Daytime Phone: ____________________ ext: __________

*Are you authorizing release of your own records? ❑Yes ❑No
If not, what is your relationship to the patient?________________________________

Release of certain medical information requires a minor's consent. This applies to persons aged 13 to 17 for information pertaining to substance abuse and mental health information, or persons aged 14 to 17 for information pertaining to sexually transmitted diseases, HIV and AIDS. Other laws may apply.

* To be Released to: (fill out contact info for each doctor to whom you want your records sent)

❑ Self (please provide current address below) **^fee may apply**
❑ Facility/Doctor's Name: ________________________________
Address: ________________________________
City: ____________________ State: __________ Zip: __________-________
Phone #: ____________________ Fax #: ____________________
❑ Facility/Doctor's Name: ________________________________
Address: ________________________________
City: ____________________ State: __________ Zip: __________-________
Phone #: ____________________ Fax #: ____________________
Please write additional Facility/Doctor information on the back

* For the Purpose of:

❑ Adjunctive/Concurrent Care ❑ Transfer of Care ❑ Other: ____________________

I understand that unless revoked this authorization is valid until the expiration date indicated below. 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..

Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to:

*** (check the accompanying box(es) below to EXCLUDE the information from authorization)**

❑ substance abuse ❑ mental health conditions/psychotherapy ❑ sexually transmitted diseases and ❑ HIV/AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.

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 at the time of signing. I may call the medical records office at (206) 834-4151 to inquire about revoking authorization.

I understand that if I request records for personal use, to hand-carry to another health provider, or for parties not involved in my health care, there may be a charge. 'Non-emergency' release of records may take up to 15 working days. Emergency requests will be given priority processing. 'Emergency' status applies only to release of records directly to another healthcare provider for urgent patient care. There is no charge to release records to another healthcare provider.

**Patient's Signature: ***________________________________ **Date ***______________

Rep./Guardian's Signature: ________________________________ **Date:** ______________

Expiration Date:* ________________________________

- [ ] Facility/Doctor's Name: ____
  Address: ____
  City: ______________________ State: __________ Zip: __________-______
  Phone #: ______________________ Fax #: ______________________

- [ ] Facility/Doctor's Name: ____
  Address: ____
  City: ______________________ State: __________ Zip: __________-______
  Phone #: ______________________ Fax #: ______________________