4520 42nd Ave. SW, Suite 34
Seattle, WA 98116

Authorization to Disclose Medical Records

This authorization must be written, dated, and signed by the patient or by a person authorized by law to give authorization.

I authorize ____ (name of hospital/health care provider)

to release a copy of the medical information for ____ (name of patient)

to **WEST SEATTLE FOOT & ANKLE CLINIC 4520 42nd AVE. SW, SUITE 34 SEATTLE, WA 98116.**

The information will be used on my behalf for the following purpose(s):____

____

By initialing the spaces below, I specifically authorize the release of the following medical records*, if such records exist:

___ All hospital recoreds (including nursing records and progress notes)

___ Transcribed hospital reports

___ Medical records needed for continuity of care

___ Most recent five year history

___ Emergency and urgent care records

___ Diagnostic imaging reports

___ Clinician office chart notes

___ Dental records

___ Laboratory reports

___ Pathology reports

___ Billing statements

___ Other: ____

___ Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

***The following items must be initialed to be included in other documents:**

___ **HIV/AIDS related records**

___ **Mental health information**

___ **Genetic testing information**

___ **Drug/alcohol diagnosis, treatment or referral information. Per federal regulations, describe how much and what kind of information is to be disclosed:** ____

___ This authorization is limited to records regarding the following treatment:_______________________________________

___ This authorization is limited to records from the following time period: ____

___ This authorization is limited to a worker's compensation claim for injuries of _______________________________(date).

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 90 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

______________________	________________________________
Date	*Signature of Patient*
______________________	________________________________
Date	*Signature of person authorized by law*