Authorization to Release Health Care Information

Patricia Paddison, MD, PLLC; 4957 Lakemont Blvd SE; Ste C-4143; Bellevue, WA 98006
www.drpaddison.com phone 425- 455-2526 Fax 1-425-484-2200

I authorize Dr Paddison to __ release/ __obtain records of:

Client name: _____ Date of birth: _____

Information to be Exchanged with: Name or Organization: _____

Address:_____Email_____

City, State: _____Zip Code: _____Phone_____ Fax_____

Release the following information:

_____ Health care information relating to the following treatment or condition:
_____

_____ Health care information for the date(s) below:
_____

_____ All health care information:
_____

_____ Other _____

This authorization ends: _____ in 90 Days; or

_____ when the following occurs (but not longer than 90 days):

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1) Sign and date a revocation form. This form is available from (physician or clinic); or
2) Write, sign and date a letter to the (physician or clinic) to cancel the authorization; or
3) Sign, date and write "CANCEL" on this original form

Once Dr. Paddison gives out the information, Dr. Paddison has no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.

I also agree to the release of health care information regarding testing, diagnosis, and/or treatment for:

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

_____ _____ _____
Patient or legally authorized individual signature Date Time