AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS AND INFORMATION

I, ___________________________________ Birthdate: ___/_____/_____

Authorize C. Michele Ingram, ARNP at Overlake Reproductive to release records to:

____

(Person/Facility)

____

Street Address City/State Zip

____

Phone # Fax #

Personal health records during the period of:____

All medical records to include the following:

_______ Lab results

_______ X-ray results X-ray#: ________________

_______ Original x-rays*

*any original X-rays so released will be promptly returned as soon as possible if necessary.

Release of information pertaining to (check in each area):

______ INCLUDES ______ EXCLUDES Drug or alcohol abuse diagnosis or treatment

______ INCLUDES ______ EXCLUDES HIV (AIDS) testing/treatment

______ INCLUDES ______ EXCLUDES Psychiatric care/mental illness

______ INCLUDES ______ EXCLUDES Confirmed STD test results and/or treatment

I understand that records are protected under confidentiality regulations, and any records that contain information regarding drug and/or alcohol abuse that are created by an alcohol abuse or drug abuse prevention program are protected under federal confidentiality laws (42 CFR Part 2) and state law. I understand that said records containing information about the diagnosis, treatment, or referral of alcohol and drug abuse problems cannot be disclosed without my written consent, and that those receiving this information are prohibited from re-disclosing these records unless expressly permitted by my written consent. I understand that any records that contain information regarding HIV and or confirmed STD tests or treatment are protected by state confidentiality laws (RCW 70.24). I understand that and HIV and/or confirmed STD tests or treatment records cannot be disclosed without my written consent unless permitted by State law, and that those receiving this information are prohibited from re-disclosing these records without my further written consent. This consent may be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

Signature : ____

Print Name: ____

Date:____________________________________

Thank You! C. Michele Ingram, ARNP - Overlake Reproductive PO Box 1189, Bellevue WA 98006