UROLOGY NORTHWEST, PS | UROLOGY NORTHWEST SURGERY CENTER
6005 244TH ST SW | MOUNTLAKE TERRACE | WA | 98043

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security #:_____ Other Last Names Used: _____

TYPE OF INFORMATION REQUESTED – PLEASE CHECK ONE

I hereby authorize the following organization to release medical information:

___ Most recent history
___ All records
___ Other: _____

This release: ☐ **May** ☐ **May not** include specific information related to testing, diagnosis and/or treatment for HIV AIDS Virus, sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use.

INFORMATION TO BE RELEASED FROM:

Organization/Person _____

Street Address_____

City_____ State____ Zip _____

Telephone_____ Fax_____

INFORMATION TO BE RELEASED TO:

Organization/Person _____

Street Address_____

City_____ State____ Zip _____

Telephone_____ Fax_____

REASON FOR THIS RELEASE: Continuance of Care

_____ _____
Signature of Patient (Or Other Responsible Person) Date

_____ _____
Relationship – If Not The Patient Signature of Witness

This authorization may be revoked in writing at any time except to the extent already relied upon and will expire in ninety (90) days unless previously revoked. You may inspect or receive a copy of the information being released. The information used or disclosed may be released by the recipient and no longer protected by the Federal Privacy Rule. You may refuse to sign this authorization to release information and this will not affect your access to care.