Overlake Reproductive Health, Inc., P.S.

AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS AND INFORMATION

I, _____________________________ Birthdate: ___/ __ / __ Authorize OVERLAKE REPRODUCTIVE HEALTH, Inc., P.S. release records to:

____

(Person/Facility)

Street Address_________________________________City________________zip_________________

Phone #_________________________________Fax #____

The following information:

Personal health records during the period of:____

___ All medical records Chart #: ______
___ Lab results X-ray #: ______
___ X-ray results
___ Original x-rays*

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

This consent __Includes __EXCLUDES 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. Record release may take 5-10 business days as the records are reviewed and signed off on by physicians per our medical process.

Signature__________________________________ Print Name_______________________________________
Witnessed_________________________________ Date____