

Sakura Women's Health

611 South Chestnut, Ste D • Ellensburg, WA 98926
509-933-8700 • 509-933-8705

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name (please print) _____

Phone #: _____ Birthdate: _____ Other Names: _____

Information to be released FROM: _____

Name of Facility or Provider

Phone/Fax # Street Address City, State, Zip code

Information to be sent TO: _____

Name of Designated Recipient

Phone/Fax # Street Address City, State, Zip code

Information to be released:

All medical records in last 5 years (Chart notes, labs, x-rays, and special tests) relating to GYN Care:

Please release all medical records for the dates specified:

Purpose for which disclosure is being made: (Please check one of the following)

Transfer of Care Physician Request Personal Other

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted disease, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*** EXCLUDE the following information from the records released (please initial):**

____ Drug/alcohol abuse/treatment & diagnosis ____ Sexually Transmitted Disease
____ HIV/AIDS diagnosis/treatment/testing ____ Mental Illness or Psychiatric diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: _____ DATE: _____

This authorization will expire 90 days from the date signed.