Authorization for Release of Patient Information

Patient Name _____ DOB_____

I hereby authorize Seattle Advanced Thyroid Health/Empower HRT PLLC
Hospital/Clinic name and provider name

located at 155 NE 100th St Suite 402, Seattle, WA 98125/3710 168th St NE, Suite A101, Arlington, WA 98223
Address

Provider Phone PH 206-925-3525 FAX 206-925-3237

the above named individual's health information as described below:

Date(s) of Service Requested (if known) or Provider: _____

Description of Information to be released: (check all that apply)

___Immunization record
___Laboratory reports
___Radiology/Imaging reports
___Radiology films
___Other_____
___Most recent history and physical
___Consultations
___Progress notes
___Entire medical record

This information may be disclosed to and used for the following individual or organization:

Individual or organization:
Phone:
Fax:
Mailing address:
Email to send secure message:

Check here if this is a STAT request

Description of the purpose of the use and/or disclosure:

Continuing Care Consultation Legal Purposes Insurance Personal Use Social Security Disability

Other: _____

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy regulations I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I understand I may revoke this authorization at any time.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed name of Patient or Patient's Representative

_____ _____
Relationship to Patient or Legal Authority (attach supporting documentation)

SUBMIT COMPLETED RELEASE FORM BY: Online https://www.seattleadvancedthyroid.com/contact
MAIL 3710 168th St NE, Suite A101, Arlington, WA 98223
FAX 206-925-3237