

AUTHORIZATION TO RELEASE PATIENT INFORMATION

PATIENT IDENTIFICATION

Patient Name _____ Date of Birth ____/____/____

SS# _____ - _____ - _____ Other Last Names Used _____

INFORMATION TO BE RELEASED FROM:

I hereby authorize the following organization to release the medical information stated below from the patient's medical record:

_____ (Organization / Person)

_____ (Street Address)

_____ (City, State, Zip)

_____ (Telephone / Fax #)

INFORMATION TO BE RELEASED TO:

_____ (Organization / Person)

_____ (Street Address)

_____ (City, State, Zip)

_____ (Telephone / Fax #)

Downey Plastic Surgery, PLLC:
Daniel Downey, MD FACS
1536 N 115th St., Suite 105 - Seattle, WA 98133
Ph: 206-368-1160 Fax: 206-368-1159

Purpose or reason: _____

<p>TYPE OF INFORMATION (check all that apply):</p> <p>____ Mammogram films</p> <p>____ Dr. Downey's clinic notes, OP notes and pathology reports</p> <p>____ PCP's recent H&P, problem list, med list and any other notes pertaining to condition being referred to Downey Plastic Surgery, PLLC.</p> <p>Other _____</p> <p>_____</p>
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<p>SPECIFIC RELEASE – REQUIRED</p> <p>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.</p>
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AUTHORIZATION:

This authorization may be revoked in writing at any time except to the extent already relied upon, and will expire in 90 days unless previously revoked. 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 of Patient (or other responsible person)

Date

Relationship (if not the patient)

Signature of Witness