

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

- Steck Medical Center**
PO Box 1267; Chehalis, WA 98532
- Centralia Specialty Center**
1707 Cooks Hill Rd.; Centralia, WA 98531
- Napavine Medical Clinic**
PO Box 147; Napavine, WA 98565
- Steck Medical Lacey**
130 Marvin Rd SE, STE 112; Lacey, WA 98503

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: _____

Address: _____ Street or Box number: _____

City: _____ State: _____ ZIP: _____

PLEASE **RELEASE** MY MEDICAL INFORMATION **FROM:**

Name of Physician/Clinic/Hospital _____

Street Address: _____

City, State, Zip Code _____

Phone: _____ Fax: _____

PLEASE **SEND/RELEASE** MY MEDICAL INFORMATION **TO:**

Name of person to receive information (Physician, Attorney, etc.): _____

Title (Physician, Attorney, etc.): _____

Street Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

I. My Authorization

You may use or disclose the following health care information (check and initial all that apply):

- All health care information in my medical record. _____ (Initial) I acknowledge, and hereby consent to such, that the released information may contain alcohol/substance abuse, psychiatric, mental health or illness, HIV/AIDS disease and/or sexually transmitted disease or genetic diagnosis/treatment.
- Health care information in my medical record relating to the following treatment or condition: _____
- Health care information in my medical record for the date(s): _____
- Other (e.g. X rays, bills).** Specify date(s): _____

Reason(s) for this authorization (check all that apply):

- Transferring care Other (specify) _____

- Please mail records** **Call when records are ready to be picked up**

This authorization ends: (This document does not permit disclosure of health information created more than 90 days after the date it is signed.)

- In 90 days from the date signed On (date): _____

- When the following event occurs: _____
(No longer than 90 days from date signed)

II. My Rights

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment).

However, I do have to sign an authorization form:

- To take part in a research study,
- To receive health care when the purpose is to create health care information for a third party, or
- For marketing purposes.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Steck Medical Group based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the L.G. Steck Memorial Clinic, PS. Or,
- Write a letter to the L.G. Steck Memorial Clinic, PS.
- **Patients transferring care to another physician will be charged up to \$1.04 per page for the first 30 pages, up to .79¢ per page for pages 31+, and applicable tax and postage by Steck's contracted copy service.**

Patient or legally authorized individual signature	Date	() - Phone Number
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative)	