Bellevue Medical Partners, PPLC
11711 N.E. 12th Street, Suite 2B • Bellevue, Washington • 98005
Phone: 425.637.1022

Consent to Share Confidential Medical Information

To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.

Patient Name: _____

Date of Birth: _____

I HEREBY AUTHORIZE BELLEVUE MEDICAL PARTNERS PLLC TO SHARE:

- ☐ All health care information
- ☐ Drug and alcohol use history and treatment
- ☐ HIV/AIDS testing and treatment
- ☐ Mental health diagnoses and treatment
- ☐ My appointment times, dates, and reasons for the visits
- ☐ My lab results
- ☐ Pregnancy testing and prenatal care ☐ Birth control/family planning
- ☐ Sexually transmitted disease (STD) testing and treatment
- ☐ The medications I am taking
- ☐ The following information:

_____

WITH THE FOLLOWING PEOPLE:

Full Name	Relationship	Phone

I understand that I may cancel this consent at any time (by writing to Bellevue Medical Partners PLLC), but that canceling it will not affect any information that has already been released. I understand that I do not have to sign this form and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

This authorization expires: ☐ When I cancel it in writing or ☐ _____

_____ _____
Signature Date

_____ _____
Witness Date