Bellevue Medical Partners, PLLC
11711 NE 12th St. #2B Bellevue, WA 98005
(425) 637-1022 FAX: (425) 637-2011

Authorization to Release Health Care Information

Patient Name: _____ Date of Birth: _____

SS#: _____Previous Name: _____

I request and authorize _____ to release health care information of the patient above to:

Bellevue Medical Partners PLLC
Richard A. Kaner, M.D.
Carolyn McHugh, M.D., MPH
Jennifer Mills, M.D., FHM
11711 NE 12th St. #2B
Bellevue, WA 98005

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____ All health care information

_____ Other: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Signature of patient or patient's authorized representative Date signed

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Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED