Sheila C. Lally, DO, PS
PO Box 2674
Poulsbo, WA 98370
(360) 697-6547
(360) 697-9277 Fax

REQUEST FOR RELEASE OF MEDICAL RECORDS

PLEASE PRINT THE FOLLOWING INFORMATION:

NAME:_____

ADDRESS:_____

BIRTHDATE:_____SSN#:_____TELEPHONE:_____

PLEASE RELEASE THE FOLLOWING RECORDS:

All Records:_____Medical Records Only: _____X-Ray Film/Reports:_____Lab:_____

Other (Please Specify): _____

Records for the period (dates) from _____ to _____

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

I AUTHORIZE: _____

To release any and all information contained in my medical records to: _____

Address:_____

Phone: _____ Fax:_____

I understand that my medical records may contain information regarding diagnosis and/or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. I release the doctor and his/her staff from all legal responsibility of liability that may arise from release of this information.

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoke this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. 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. This authorization expires in 90 days from the date signed.

PATIENT SIGNATURE:_____DATE: _____

_____

Signature of Parent/Legal Guardian/Personal Representative Relationship to Patient