Home Towne Family Medicine
Experience Health

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information

_____ **DOB** _____ **SS#** ____-___-_____
(Patient Name)

Information to be released from _____
(Name of designated Facility or Provider)

_____
(Address)

Information to be Released to **Dr. Jack Choi Whitney Hogan, ARNP**
Home Towne Family Medicine
15580 3rd Ave SW, STE 101
Burien, WA, 98166
p. 206-453-4215 f. 206-453-4234

Information to be Released

☐ The most recent 2 years of pertinent information. (chart notes, labs, x-rays, and special tests)

☐ All medical records.

☐ Specific information (Please specify) : _____

Patient Authorization

I understand that my records may contain information regarding HIV/AIDS, sexually transmitted diseases, drug and /or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*EXCLUDE the following information from the records release (please initial)

___ Drug/Alcohol abuse
___ HIV/AIDS
____ Sexually Transmitted Disease
____ Mental or Psychiatric Illness

My Rights

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 revoking 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.

Signature _____ **Date** _____
(Patient, Guardian, or Authorized Representative)
(If not patient, please provide documents to prove authority to sign on behalf of the patient)

Revised : 02/20/2020 jc

This authorization will expire 90 days from the date signed.