Date

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

RELEASE RECORDS FROM	SEND RECORDS TO
	Island Internal Medicine
Name of Organization	Name of Organization
	912 32nd Street, Suite A
Mailing Address	Mailing Address
	Anacortes | WA | 98221
City | State | Zip	City | State | Zip
	360-293-4343 | 360-588-1587
Telephone | Fax	Telephone | Fax

Reason For Request

I request that my medical records be released to the person(s) or Institution named above.

I understand that my express consent is required to release information relating to sexually transmitted disease including HIV/AIDS, mental illness and/or drug or alcohol abuse. If I have been tested, treated or diagnosed in connection with any sexually transmitted disease including HIV/AIDS, drug or alcohol abuse, and/or mental illness, you are specifically authorized to release to the person(s) or institution named above all information or medical records relating to such diagnosis, testing or treatment unless specifically excluded below.

I understand that the subsequent use or release of this medical information cannot be limited or controlled by the person(s) or institution releasing these records. This request is a free and voluntary act by me. I hereby release all legal responsibility that may arise from the release of the medical information as authorized by me. You have the right to revoke or cancel this authorization, in writing, at any time.

SPECIFICALLY EXCLUDE:_____

SPECIFICALLY INCLUDE:

- ☐ Medical Records (Any and All)
- ☐ Medical Records (Last 2 Years Only)
- ☐ Most Recent Physical
- ☐ Labs/Pathology
- ☐ Radiology Reports
- ☐ Colonoscopy Reports
- ☐ Operative Reports
- ☐ Other:_____

Patient Name | Date of Birth | Social Security Number

Signature of Applicant | Date