Date

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

RELEASE RECORDS FROM	SEND RECORDS TO
Name of Organization:	Name of Organization: La Conner Medical Center
Mailing Address:	Mailing Address: PO Box 1620
City: / State: / Zip:	City: La Conner / State: WA / Zip: 98257
Telephone: / Fax:	Telephone: 360-466-3136 / Fax: 360-466-0107

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