ADD Center of Bellevue

David P. Pomeroy, M.D., P.S.
Annelise Joslin P-ARNP
2000 116th Ave NE, Suite 6 ● Bellevue, WA 98004
Telephone: (425) 454-8684 ● Fax: (206) 339-5465
Email: info@addcenterofbellevue.com
www.addcenterofbellevue.com

AUTHORIZATION TO EXCHANGE HEALTHCARE INFORMATION

____________________________________	____________________________________
Patient Full Name	Date of Birth and Social Security Number
____________________________________	____________________________________
Patient Previous Name if applicable	Date of Authorization
	____________________________________
	Day Time Phone

Information to be released from:
ADD Center of Bellevue
2000 116th Ave NE, Suite 6
Bellevue, WA 98004

Information to be released to:
____
____
____

Type of Records Requested:

- Health care information related to the following treatment or condition:____________________________________
  ____
- Laboratory/diagnostic tests________________________
- Other____

Sensitive Records may require specific patient authorization
Please initial the appropriate records requested:
- Mental Health

Date range of information needed: Period beginning _______________ (date) and ending:_______________ (date)

Patient Rights:

I understand that my medical and mental health information and records are protected by Federal and State confidentiality laws and regulations and cannot be released without my written consent unless otherwise provided for in those laws and regulations. I also understand that I may revoke this consent in writing at any time unless action has already been taken based upon it.

I understand that my right to confidentiality under Federal law and regulations does not protect any information about a crime committed or suspected child abuse or neglect. In addition, if there is reason to suspect that I am in danger of physical, bodily harm or that anyone else is in danger of physical, bodily harm, that information is not protected under Federal regulations.

I understand that information about HIV/AIDS, sexually transmitted disease, mental health, and drug or alcohol treatment can be released only if I sign the special consent below.

Date:___________ ____
Signature of patient or au authorized personal representative

____
Minor signature if required