Steck Medical Group – 1299 Bishop Rd PO Box 1267 Chehalis WA 98532 FAX 360- 262-3679

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

❑ **Steck Medical Center**
PO Box 1267; Chehalis, WA 98532

❑ **Centralia Specialty Center**
1707 Cooks Hill Rd.; Centralia, WA 98531

❑ **Steck Medical Lacey**
130 Marvin Rd SE, STE 112; Lacey, WA 98503

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: _____

Address: _____ Street or Box number: _____

City: _____ State: _____ ZIP: _____

PLEASE **RELEASE** MY MEDICAL INFORMATION **FROM:**

Name of Physician/Clinic/Hospital _____

Street Address: _____

City, State, Zip Code _____

Phone: _____ Fax: _____

PLEASE **SEND/RELEASE** MY MEDICAL INFORMATION **TO:**

Name of person to receive information (Physician, Attorney, etc.): _____

Title (Physician, Attorney, etc.): _____

Street Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- ❑ All health care information in my medical record.
- ❑ Health care information in my medical record relating to the **following treatment or condition**: _____
- ❑ Health care information in my medical record for the date(s): _____
- ❑ Other (e.g. X rays, bills). Specify date(s): _____

INCLUDE the following information from my records released (MUST initial). I understand that my records may contain information regarding the following sensitive diagnosis or treatment. If the item is initialed, then I give my specific authorization for these records to be released.

_____Alcohol/Substance abuse

_____Psychiatric disorders/Mental Health

_____HIV/AIDS virus and/or sexually transmitted disease or genetic diagnosis/treatment

Reason(s) for this authorization (check all that apply):

- ❑ Transferring Care
- ❑ Other (specify) _____
- ❑ **Please mail records**
- ❑ **Call when records are ready to be picked up**
- ❑ **Paper Copy or CD (Please Circle One)**

This authorization ends in 90 days from the date signed, or (on date specified): _____ _____ (initial)

NOTE: Patients transferring care to another physician will be charged a $24.00 clerical fee and to $1.09 per page for the first 30 pages, .82¢ per page for pages 31+, and applicable tax and postage by Steck's contracted copy service. Per RCW 70.02.010(15)

II. My Rights

I understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it. I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Steck Medical Group based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

_____ _____ (____) ____-_____

Patient Signature or legally authorized individual (guardian, patient advocate) Date Phone Number

*__NOTE:__ An electronic signature will not be accepted

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)