

**AUTHORIZATION TO DISCLOSE MEDICAL RECORDS**

**PATIENT INFORMATION:**

- 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 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)