Cascade
FAMILY MEDICINE
AESTHETICS & AVIATION

16500 SE 15th St, Suite 100 Vancouver, WA 98683
360-254-4402 Fax: 360-892-9241

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name_____

Date of Birth: _____ **SS#** _____

Previous Names_____ **Telephone#**_____

ADDRESS:_____

- I understand that my personal health records are protected under state and federal confidentiality laws and cannot be disclosed without my written consent except in specific instances described by law. The undersigned hereby authorizes the release of personal health and medical information

I request and authorize the following to release all personal health and medical information:

NAME:_____
Attn:_____
Address:_____
City:_____**State:**_____**Zip Code:**_____
Telephone_____ **Fax:**_____

Please release the requested information regarding my personal health and medical information and treatments to:

CASCADE FAMILY MEDICINE, AESTHETICS & AVIATION
16500 SE 15th St, Suite 100 Vancouver, WA 98683
Phone: 360-254-4402 Fax: 360-892-9241

This request and authorization applies to all health care information relating to any medical testing, diagnosis, treatment, and condition, for any and all dates of service.

Initial

- I give my express consent to release any and all of my health care information relating to testing, diagnosis, and/or treatment including HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, and drug/alcohol use.

Initial ____

- I understand that I have the right to revoke this Authorization at any time, provided I do so in writing. I understand that I am personally responsible for any related fees for copying or administrative time related to complying with this request.

XX_____ _____ **//** _____

Signature of patient or patient's authorized representative **Date signed**

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.) _____