



The Seattle Arthritis Clinic

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient Name _____ Date of Birth ____/____/____ SS# _____-_____-_____

Other Last Names Used _____

INFORMATION TO BE RELEASED FROM:

I hereby authorize the following organization to release the medical information stated below from the patient's medical record:

The Seattle Arthritis Clinic **or**

_____ (Organization / Person)
_____ (Street Address)
_____ (City, State, Zip)
_____ (Telephone / Fax #)

INFORMATION TO BE RELEASED TO:

_____ (Organization / Person)
_____ (Street Address)
_____ (City, State, Zip)
_____ (Telephone / Fax #)

The Seattle Arthritis Clinic
10330 Meridian Ave N, Ste 250
Seattle, WA 98133
Phone: (206) 368-6123
Fax: (206) 368-6178

_____ Julie L. Carkin, MD
_____ Richard A.H. Jimenez, MD
_____ Steven S. Overman, MD
_____ Jeff R. Peterson, MD
_____ Andrew K. Solomon, MD
_____ Marilee M. Jensen, ARNP

TYPE OF INFORMATION:

- _____ Any and all records
- _____ Recent progress notes(typed),labs, Recent MRI's & initial consult note
- _____ Diagnostic tests, labs, med list & Problem list
- _____ Previous Rheumatology lab tests
- Other _____

SPECIFIC RELEASE - REQUIRED

This release [] **MAY** [] **MAY NOT**
Include specific information related to testing, diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.

AUTHORIZATION:

This authorization may be revoked in writing at any time except to the extent already relied upon, and will expire in 90 days unless previously revoked. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

Signature of Patient (or other responsible person)

Date

Relationship (if not the patient)

Signature of Witness