AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____

Date of Birth:_____SSN:_____

I REQUEST AND AUTHORIZE:

NAME:_____

ADDRESS:_____

CITY/STATE/ZIP:_____

OFFICE PHONE:_____FAX:_____

TO RELEASE PHI AND OTHER HEALTHCARE INFORMATION OF THE ABOVE NAMED PATIENT TO:

Eastside Nephrology & Hypertension
Astier Alem, MD
13030 121st Way NE #102
Kirkland, WA 98034
(425) 899-5111 / Fax (425) 899-5114

This request and authorization applies to: (CHECK ONE)

_____ Healthcare information related to the following condition, treatment, or dates of service.
_____
_____

_____ALL Healthcare information, including (1) alcohol and/or drug abuse treatment, (2) psychiatric diagnosis, treatment and summaries, (3) test results for HIV, STD, and (4) treatment of HIV, STDs, AIDS and related conditions.

I give my specific authorization for these records to be released. In return for releasing these records in response to my request, I release you and your staff from all legal responsibility or liability that may arise from the release of this information. I may revoke this consent at any time in writing, except that revocation will not affect any releases of records, which have taken place prior to receipt of revocation.

This authorization to release records expires ninety days from the date signed. Further release of this information to other parties may not be done without further authorization from me.

_____ _____
Authorized Signature Date Signed

_____
Relationship to patient if signed by anyone other than patient