Authorization to Release Information

Creekside Medical

P: 360-566-9355 F: 360-816-1327

Patient name:		Date of birth:		
Previous name:		Phone:		
Parents' names:				
Creekside Medical may OBTAIN my healthcare information from:	OR	SEND my healthca	are information to:	
Name or organization:				
Email (Preferred):				
Address:	_ City:	State:	Zip:	
Phone:	_ Fax:		MASSIVA	
I. Information to be disclosed or received: (chec Immunization Record(s) Most recent clinic note, date: All Progress Notes, Last 3 years Other: Please Note: All of the following Sensitive Healthcare inf	□ E □ L □ R	KG aboratory Tests, Last 3 y adiology / Imaging, Last	3 years	
be included unless otherwise initialed.	onnation re	egarding testing, diagnosis,	and treatment win	
*Please Do Not Send (Initial all that apply):				
HIV (AIDS virus) Drug and or Alcohol Abuse S	Sexually Tra	nsmitted Disease Behav	ioral or Mental Health	
	•		☐ Insurance Claim ☐ Other:	
III. My Rights I understand that this authorization is voluntary and I may refuse and the payment of my health care will not be affected if I do not be used or disclosed and that once health care information is disprivacy laws may no longer protect it.	ot sign this fo	orm. I understand I may inspec	t or copy the information to	
III. This authorization ends: (This document does not 90 or 180 days after the date it is signed.)		closure of health information o Name:	created more than	
90 days from the date signed below180 days from the date signed below	900	ekside Medical, PS NE 139 th Street, Ste 202 couver, WA 98685	P: 360-566-9355 F: 360-816-1327	
authorize the transfer of my health care information to o be made for transfer of information to another health care me, my family member, another person or third party sucl \$25.00 plus \$1.17 per page for the first 30 pages, and \$0 are rendered.	e facility. Ho h as an atto	owever, if health care inform orney or insurance compan	nation is transferred to y, the charge will be	
Patient's signature if 13 years or older*		Date	Time	
Parent or legal guardian signature		Relationship (parent or le	egal guardian)	