

SEATTLE OB/GYN GROUP  
1101 MADISON ST # 950  
SEATTLE, WA 98104  
(206) 682-5800 PHONE  
(206) 233- 9657 FAX

**MEDICAL RELEASE AUTHORIZATION**  
**(Please send this to the office that you are transferring from)**

NAME: \_\_\_\_\_  
Last First Middle Maiden

TELEPHONE NUMBER: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

Information to be released **FROM**: \_\_\_\_\_

Address \_\_\_\_\_  
City, State, Zip Code Phone Number

Information to be released **TO**: \_\_\_\_\_

Address \_\_\_\_\_  
City, State, Zip Code Phone Number

**PURPOSE OF RELEASE:**

- Transferring Care
- Moving Out of the Area
- Health Insurance Change
- Personal
- Appointment with a Specialist
- Continuing Care with PCP
- Other \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

- The most recent 2 years of pertinent information or less than 10 pages.  
(Chart notes, labs, x-rays and special tests) **NO CHARGE**
- All Medical Records **CHARGED ACCORDING TO THE RECORDS FEE SCHEDULE BELOW**
- Specific information:(Please Specify)\_\_\_\_\_

**RECORDS FEE:**

**Patient and Third Party Vendors (PRE-PAY ONLY)**  
\$23.00 Clerical / Search Fee  
\$1.04 per page for the first 30 pages  
\$.79 per page for additional pages over 30

**NO CHARGE TO RELEASE RECORDS DIRECTLY TO ANOTHER PROVIDER**

The schedule of charges above is created and regulated by the Washington State Uniform Health Care Information Act, RCW 70.02 Section 102(12) and an authorization does not have to be honored until the fee is paid.

**Patient Authorization:**

This authorization includes records that may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. If I do not want these specific records disclosed, I will cross those items out from the sentence above.

**My Rights:**

- I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:
  - To take part in a research study or
  - To receive health care when the purpose is to create health care information for a third party.
- I understand that I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Seattle OB/GYN Group based upon this authorization. I understand that there are two ways to revoke this authorization:
  - Filling out a revocation form. A form is available from Seattle OB/GYN Group. Or
  - Writing a letter to Seattle OB/GYN Group (1101 Madison St. Ste 950, Seattle, WA 98104) stating that I revoke this authorization.
- I understand that once health care information is disclosed, the person or organization that receives it may not be required to maintain the confidentiality of my health care information. Therefore, it may be redirected and privacy laws may no longer protect it.

**PATIENT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Guardian or Authorized Representative: Please provide documents to prove authority to sign on behalf of the patient.

**This authorization will expire 90 days from the date signed**