Bellegrove Obstetrics & Gynecology Inc., P.S.

Authorization to Release Health Care Information

(Records Coming In)

Patient's Name _____ DOB _____

Previous Name _____ SSN _____

Contact Telephone _____ e-mail address _____

To: _____
(Name of former provider) Address City State Zip

Fax Number: _____ Telephone Number: _____

I request and authorize you to release health care information of the patient named above to:

☐ Dionne Gallagher, M.D. ☐ Hal Zimmer, M.D ☐ Mitchell Nudelman, M.D ☐ Keely Brown, M.D
☐ Elisabeth Anton, M.D ☐ Heather Moore, M.D ☐ Jennifer Heuberger, A.R.N.P ☐ Laura Zaccari, PAC
☐ Lindsay Jandl, A.R.N.P

Bellegrove OB/Gyn, Inc. P.S.
1200 112th Ave NE Suite 115
Bellevue, WA 98004
(425) 455-0244 (425) 455-9411 FAX

This request and authorization applies to:

_____ All Records

_____ Information relating to the following treatment, or dates of treatment:

_____

_____

Other: _____

Purpose for which disclosure is being made: _____

My Rights:
I understand I do not have to sign this authorization in order to get 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 information for a third party. I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to our patients. I understand that once health information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.**

***EXCLUDE** the following information from the records release (please initial):

_____ Drug/alcohol abuse/treatment & diagnosis _____ Sexually Transmitted Disease

_____ HIV/AIDS diagnosis/treatment/testing _____ Mental Illness or Psychiatric diagnosis/treatment

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), STD's, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all care information relating to such diagnosis, testing or treatment.

_____ _____
(Signature of patient or patient's authorized representative) (Date)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED