# Bellegrove Obstetrics & Gynecology Inc., P.S.
## Authorization to Release Health Care Information
*(Records Going Out)*

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:

- ☐ Hal Zimmer, M.D
- ☐ Mitchell Nudelman, M.D
- ☐ Elisabeth Anton, M.D
- ☐ Heather Moore, M.D
- ☐ Keely Brown, M.D
- ☐ Dionne Gallagher, M.D
- ☐ Kylie Smith, D.O
- ☐ Laura Zaccari, PAC
- ☐ Jennifer Heuberger, A.R.N.P
- ☐ 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*

## Bellegrove Ob/Gyn
## Medical Records Release Policy and Procedure

In response to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, physicians have been faced with greater complexities when releasing medical records. In an effort to protect patient confidentiality, as well as comply with government regulations, Bellegrove Ob/Gyn has teamed with Secure health Information, Inc. to provide all copying services. Secure Health Information, Inc. insures that your confidential medical records are handled meeting all necessary guidelines.

Medical Records will be release only upon written request from the patient. Written requests must be in accordance with the Uniform Health Care Information Act.

The requirements for a valid authorization to release medical records are:

- In writing, dated and signed by patient
- Specifically identifies patient
- Specifically identifies the health provider who is to make the disclosure
- Specifically identifies the information to be disclosed
  Note: *An authorization which affects a medical record in which information concerning the performance or results of HIV (AIDS virus), STD testing, substance abuse, and mental or psychiatric treatment must specifically authorize the release of such test and/or treatment information or it will be excluded from the records release.*
- Specifies the name, address and institutional affiliation of the person or entity to whom the information is to be disclosed

Except for authorizations to provide information to third-party payers, authorizations are valid for 90 days. Patients can specify a shorter period of time if desired.

Revocation must be in writing; an authorization can be revoked at any time unless:

Needed to secure payment for services rendered; or
Other substantial actions have been taken in reliance on the authorization
(e.g. a claim ahs been made under a life insurance or disability policy)

There is a fee for all copies made by IOD, Inc., including transfer of care. The current schedule of charges below is created and regulated by the Washington State Uniform Health Care Information Act, RCW 70.02.010 and an authorization does not have to be honored until the fee is paid. Fees are subject to change as the state update allowed fee schedules:

**$ 26.00 Clerical / Search fee**
**$ 1.17 Per page for the first 30 pages**
**$ .88 Per page for additional pages over 30**
**Postage or delivery actual cost**
**Applicable Washington State sales tax**

IOD, Inc. follows state guidelines for records release and copying fees. When requesting release of medical records you may want to take above fees under consideration, requesting only needed information.

Revised 1/19