AUTHORIZATION TO RELEASE MEDICAL INFORMATION

SEATTLE HAND SURGERY GROUP
600 BROADWAY, SUITE 440
SEATTLE, WA 98122
(206) 292-6252

Carleton A. Keck, Jr., M.D.
William F. Wagner, Jr., M.D.
John A. Miyano, M.D.
Elizabeth S. Joneschild, M.D.
Beverlie L. Ting, M.D.

I give Seattle Hand Surgery Group, PC permission to ☐ release to ☐ obtain from:

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone: ______________ Fax: ______________

The medical records of:

Last name: ______________ First name: ______________ Middle/Maiden: ______________

Address: ______________________________

Date of Birth: ______________ Contact #: ______________

Containing the following information (specify dates):

☐ All Medical Records ______________ ☐ Discharge Summary ______________

☐ ER Records ______________ ☐ Operative Report ______________

☐ Lab/EKG ______________ ☐ Imaging ______________

☐ History & Physical ______________ ☐ Other ______________

I understand my records may contain information regarding diagnosis or treatment of substance abuse, HIV/AIDS, sexually transmitted diseases or mental/psychiatric illness. Exclude the following information from the records released:

☐ Mental health/psychiatric records ☐ Substance abuse records ☐ Sexually transmitted diseases ☐ HIV (AIDS virus)

For the purpose of: ☐ Continued care ☐ Attorney ☐ Personal ☐ Other: ______________

PATIENT RIGHTS: I understand that I have the right to withdraw this authorization at any time, except for action already taken, and that such revocation must be in writing. Contact Seattle Hand Surgery Group, PC for a revocation form or write a letter of revocation.

Release of information authorized herein may result in the waiver by the patient of certain legal rights, including the protection of the physician/patient privilege.

REDISCLOSURE PROHIBITED: I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

I understand that I do not have to sign this authorization in order to receive healthcare benefits.

______________________________ ______________________________ ______________

Signature of Patient or Legally Responsible Party **Authority to sign, if not Patient** **Date (MM/DD/YR)**
(A minor patient's signature may be required)

This authorization expires in 90 days from the date signed or on the following day/event: ______________

You may be charged a fee for processing and copying of your medical records in compliance with 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 fees are paid.

X-Rays taken prior to October 2016 require digitizing prior to release. You will be charged the fee paid by Seattle Hand Surgery Group, PC with no mark-up. The current fee is $16.45 per x-ray. The processing time averages 21 days from receipt of payment.