Olympia Neurology PLLC

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

IMPORTANT: READ ALL INFORMATION ON THIS FORM BEFORE SIGNING

Patient's Name: _____ **Birth date:** _____
(Please print) LAST FIRST MI mm/dd/yyyy
Are medical records filed under another name?_____ Phone: _____

Information to be released by:	**Information to be released to:**
☐ Olympia Neurology	☐ Olympia Neurology
☐ _____	☐ _____
Clinic/Organization/Person's name	Clinic/Organization/Person's name
_____	_____
Street address	Street address
_____	_____
Phone Fax	Phone Fax

☐ Complete Medical Record Abstract (chart notes, most recent labs/pathology & diagnostic imaging reports
☐ Healthcare information in my medical records regarding treatment or condition: _____
☐ Healthcare information for the date(s) of: _____ to _____
☐ Other (e.g., imaging, studies and billing) for the date of: _____

REASON FOR REQUEST: ☐ Personal ☐ Transfer of Care ☐ Disability ☐ Insurance ☐ Legal Review
☐ Other reasons (please explain): _____

MINORS AGE 13-17: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care, including, but not limited to: contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older). (2) alcohol and/or drug abuse (age 13 and older). (3) Mental health conditions (age 13 and older).
Minor's signature_____ Date _____

SENSITIVE INFORMATION: This authorization includes the release of the following sensitive information unless specifically excluded. Please initial if you DO NOT want this information included.
____Mental Health ____ HIV/AIDS ____ Sexually Transmitted Disease ____ Drug/Alcohol treatment

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. I understand I have the right to revoke or cancel this authorization, in writing, at any time.

This authorization expires _____ (date or event) Authorization will expire in 90 days if not otherwise specified

Patient Signature: _____ Date _____

Print Name: _____

Parent or Legal Guardian Signature: _____ Date _____

Print Name: _____ Relationship to Patient (if other than patient) _____