



Bellegrove Obstetrics & Gynecology Inc., P.S.

Authorization to Release Health Care Information (Records Coming In)

Patient's Name _____ DOB _____

Previous Name _____ SSN _____

To: _____
(Name of former provider)

(Address)

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Dr. Ronald Coe | <input type="checkbox"/> Dr. Hal Zimmer | <input type="checkbox"/> Dr. Mitchell Nudelman |
| <input type="checkbox"/> Dr. Elisabeth Anton | <input type="checkbox"/> Dr. Heather Moore | <input type="checkbox"/> Dr. Keely Brown |
| <input type="checkbox"/> Laura Zaccari, PA-C | <input type="checkbox"/> Jennifer Heuberger, ARNP | <input type="checkbox"/> Lindsay Hurd, ARNP |

Bellegrove OB/Gyn, Inc. P.S.
1200 – 112th Ave NE
Suite C-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 healthcare 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 released (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. Unless excluded above, 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 health 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