



# Bellegrove Obstetrics & Gynecology Inc., P.S.

## Authorization to Release Health Care Information (Records Going Out)

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_  
Previous Name \_\_\_\_\_ SSN \_\_\_\_\_

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

- |  |   |  |
|--|---|--|
| <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 – 112<sup>th</sup> Ave NE  
Suite C-115  
Bellevue, WA 98004  
425-455-0244 425-455-9411 FAX

**To:** \_\_\_\_\_  
(Name of new provider)  
\_\_\_\_\_  
(Address)  
\_\_\_\_\_

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*