Queen Anne Medical Associates, PLLC
200 W. Mercer Street - #104 · Seattle, WA 98119 · Phone: (206)-281-7163 Fax: (206)-281-5088

Authorization for Release of Medical Records

To Be Released From:

☐ _____ **OR** ☐ **Queen Anne Medical Assoc., PLLC**
200 West Mercer St. – Suite #104
Seattle, WA 98119 (206) 281-7163

_____

_____

_____

And Sent To:

Queen Anne Medical Assoc., PLLC
200 West Mercer St. – Suite #104
Seattle, WA 98119 (206) 281-7163

____ Linda Gromko, MD
____ Mary Ellen Maxell, ARNP
____ Carol Keenholts, ARNP

OR ☐ _____

_____

_____

_____

Information To Be Released:

____ All health care information in my medical record
____ The last 2 years of my health care information
____ Only specific information related to the following: _____
____ Other (e.g., labs, X rays, Immunizations, Bills, …): _____

Certain medical information requires specific authorization to be released. By checking the box, I am specifically authorizing the release of any diagnosis and/or treatment relating the following conditions:

□ HIV/AIDS □ Mental Illness or Psychiatric Disorders □ All of these
□ Sexually transmitted diseases □ Drug and/or Alcohol Abuse

Reason For This Authorization:

□ Personal □ Medical Services □ Insurance □ Attorney □ Other: _____

Patient's Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. Once health information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Printed Full Name of Patient — Patient's Date of Birth

_____ _____
Maiden Name or Other Name — Today's Date

_____ _____
Signature of patient or legally responsible person — Relationship to Patient

This authorization will expire 90 days from the date signed, unless you specify otherwise. A copying fee may be required.