

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)**

**B**allinger **C**linic, PLLC 6007 B 244<sup>th</sup> St SW Mountlake Terrace, WA 98043  
Phone 425.640.4830 Fax 425.640.4885

Printed Name of Patient \_\_\_\_\_ Previous Names if Applicable \_\_\_\_\_

Date of Birth \_\_\_\_\_ Daytime Phone Number \_\_\_\_\_

SEND INFORMATION TO: (must be specific)

Provider Name/ Organization \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Fax \_\_\_\_\_

INFORMATION RELEASED FROM: (must be specific)

Provider Name/ Organization \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Fax \_\_\_\_\_

PURPOSE OF DISCLOSURE:       Referral/Specialist       Other  
 Transfer of Care               Personal Records

INFORMATION TO BE DISCLOSED:

Medical Records from last two years  
 Summary Health Information (*specify date(s) of service*) \_\_\_\_\_  
 Complete Record  
 Other \_\_\_\_\_

Date \_\_\_\_\_ Signature of Patient or Representative \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Authorization Expiration Date (or event) \_\_\_\_\_ (90 Days from Date)

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release for healthcare information relating to the testing, diagnosis, or treatment for:

HIV/ AIDS Virus \_\_\_\_\_                      Mental Health/ Psychiatric Disorders \_\_\_\_\_  
Sexually Transmitted Diseases \_\_\_\_\_      Drug, Alcohol Abuse/ Treatment \_\_\_\_\_

Date \_\_\_\_\_ Signature of Patient or Representative \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

*Note: There may be fees associated with the processing of your records request. If the patient is unable to sign, please indicate such and your authority to act for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our notice of Privacy Practices for instructions on how to revoke this authorization. Please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected. You have the right to refuse to sign this authorization. We will not condition treatment on the completion for this authorization.*