

**Authorization for Western Washington Medical Group to  
RELEASE HEALTHCARE INFORMATION**

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Please print \_\_\_\_\_ mm / dd / yyyy

**Please release my healthcare information... (PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE)**

**From:**  
 Western Washington Medical Group  
 1728 W. Marine View Dr., Suite 110  
 Everett, WA 98201

**Which WWMG Clinic are you requesting records from?**  
 \_\_\_\_\_

**Send Records To:**  
 Name/Organization: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone number: (\_\_\_\_\_) \_\_\_\_\_ -  
 Fax number: (\_\_\_\_\_) \_\_\_\_\_ -

**REQUIRED: I consent to release (please check ONE of the following):**

ALL healthcare information (last 3 years)

**Specific CONDITION:** Healthcare information, including x-rays, and lab results, related to the **below-listed treatment or conditions**.  
 Specifically: \_\_\_\_\_

**Specific DATES:** Healthcare information for the **below-listed date(s)**.

Specifically: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Mutual exchange of information with provider: \_\_\_\_\_ (expires 1 year from date of signing).

I do not consent to the release of health care information regarding testing, diagnosis and/or treatment for:  
 (CHECK those items you wish to EXCLUDE)

HIV (AIDS virus) ..... Sexually transmitted diseases ..... Psychiatric disorders/mental health ..... Drug and/or alcohol use ..... Patient initials \_\_\_\_\_

Purpose for which discloser/transfer of record is made:

Attorney       Insurance       Provider       Personal (to patient) \*service fee may apply

This authorization expires in 90 days or until the following occurs: \_\_\_\_\_

I may cancel this authorization in writing as allowed by law. If I do not provide an expiration date or event, this authorization will expire in ninety (90) days of the date of authorization. Once Western Washington Medical Group gives out the information, we have no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.

By signing this form, I acknowledge that I have read and agree to the terms articulated in this authorization form. I understand that I do not have to sign this authorization in order to receive healthcare benefits (treatment, payments or enrollment).

**Patient Signature:** \_\_\_\_\_ **Today's date:** \_\_\_\_\_

**Parent/legally authorized patient representative:** \_\_\_\_\_ **Today's date:** \_\_\_\_\_

**Relationship to patient (if signed on behalf of patient):** \_\_\_\_\_

**>> For information on where to submit your form, visit [wwmedgroup.com/medical-records-request](http://wwmedgroup.com/medical-records-request) and refer to the contact info on the chart. <<**

**OFFICE USE ONLY! ↓**

Disposition of Request:

Faxed

Mailed

Emailed

Date: \_\_\_\_\_ Initials: \_\_\_\_\_