CREELMAN FAMILY PRACTICE PLLC

Paul Creelman, MD Sondra Beck, ARNP
712 S. Burlington Blvd. – Burlington, WA 98233- (360) 757-0027

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

PATIENT IDENTIFICATION:

Patient Name: (please PRINT) _____

Birthdate: _____ **SS#:** _____

RELEASE INFORMATION FROM:

Provider/Facility: _____

Address: _____

City,State,Zip: _____

Phone: _____

CHART BY MAIL ONLY TO: **WE DO NOT ACCEPT CHART BY FAX OR EMAIL**

Recipient:	**CREELMAN FAMILY PRACTICE PLLC**
Address:	**712 S. BURLINGTON BLVD.**
City,State,Zip:	**BURLINGTON, WA. 98233**
Phone:	**(360) 757-0027**

MY AUTHORIZATION :

Release the Following Health Care Information:

☐ **The most recent 2 years of pertinent information (chart notes, labs, x-rays, special tests)**

☐ **All health care information in my medical record**

☐ **Health care information relating to the following condition:** _____

☐ **Health care information for the following dates:** _____

☐ **Other:** _____

Exclude the Following Information from Release:

☐ **HIV (AIDS virus)** ☐ **Sexually transmitted diseases** ☐ **Psychiatric disorders/mental health** ☐ **Drug and/or alcohol use**

Purpose for Disclosure:

☐ **Doctor** ☐ **Attorney** ☐ **Insurance** ☐ **Personal**

MY 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. Revocation would not affect any actions already taken by the practice/facility based upon this authorization. Once health care information is disclosed, the person or organization receiving the information may re-disclose it. Privacy laws may no longer protect it. This authorization will expire 90 days from the date signed. A possible copying fee may be required.

Signature _____ **Date** _____
Patient or legally authorized individual

Printed Name _____ **Date** _____

If signed on behalf of the patient **Relationship** _____ **CFP 8/31/18**