Type to enter text

Dr. Jessica (Nikki) Myhre
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Authorization to Release Medical Records

Patient Name: _____

Date of Birth: _____

Previous Name (if applicable): _____

Information to be released from:

Name (Facility or Provider):
_____ Phone Number: _____ Fax Number: _____
Address:
_____

Information to be sent to (via fax if at all possible):

Jessica (Nikki) Myhre Phone: (360) 322-1281 320 E 5th St, Port Angeles, WA 98362 Fax: (360) 228-7084.

Information to be released:

X The most recent 2 years of pertinent information (chart notes, labs, imaging, special tests, vaccines) All medical records

X Specific information (please specify): **Lab results, imaging, consultant notes**

Purpose for which the disclosure is being made:

X Doctor/Medical/Continuity of Care ____ Personal ____ Insurance ____ Attorney

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.
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

My rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing to the Practice. I understand that once this health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____ (Patient, Guardian, or Authorized Individual)

This authorization expires 90 days from the date signed. Possible copying fee required.

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