Bellingham Family Medicine
Authorization Form for Release of Records and Information

This document authorizes the use and/or disclosure of confidential protected health information about the following person in accordance with my directions as checked below:

Patient Name: ______________________________ Birthday: _______________________
Address:___________________________ City/State/Zip: ___________________________

I authorize the disclosure of information to from (circle) :

John Nuetzmann, DO – Bellingham Family Medicine, PLLC
12 Bellwether Way #230, Bellingham WA 98225. Phone 360-738-7988 Fax 360-738-4072

I authorize the obtaining of information to from (circle):

Name of person or organization: ____
Address:___________________________ City/State/Zip: ___________________________
Phone Number: ( ) ______________ Fax Number: ( ) ______________________

Records I authorize to obtain/disclose:

___ (a) all information contained within these dates: ____________________________
___ (b) my entire medical record, including HIV and sexually transmitted disease test results, mental health, alcohol, and drug use.
___ (c) other (describe information in detail including specific exclusions that I do NOT want disclosed): ____
____

I authorize the disclosure and/or use for the following reason(s):

___ (a) I am transferring care or moving.
___ (b) for my own purposes
___ (c) Other(describe reasons in detail): _______________________________________
____

I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire one (1) year after the date on which the Authorization is signed. To revoke the Authorization I must contact the privacy officer at Bellingham Family Medicine. I understand that this information may no longer be protected after it is released from Bellingham Family Medicine. I understand that the releasing party may charge a clerical and/or copying fee for this request.

Authorization and Signature:

____ ____________________
Patient or Legally Authorized Representative's Signature Date

____ ____________________
Printed name of Patient or Legally Authorized Representative Relationship (Self, Parent, etc)