

Records Release Authorization

Patient Name _____ **Date of Birth** _____ **SSN#** _____
Previous Name(s) _____

Information to Be Released *From*:

- Robert Kanter, M.D., P.S. or Nancy Niles, M.D.
 Or _____ (Physician or Hospital)
_____ (Street Address)
_____ (City, State, Zip code)
_____ (telephone/fax)

Information to Be Released *To*:

- Robert Kanter, M.D., P.S. or Nancy Niles, M.D.
1530 N 115th St. Suite #208
Seattle, WA 98133
Telephone: 206-362-0035 Fax: 206-362-6927
- Or _____ (Physician or Hospital)
_____ (Street Address)
_____ (City, State, Zip code)
_____ (telephone/fax)

I hereby authorize and request you release the following medical information:

- All** health care information in my medical records
- Health care information in my medical records relating to the following condition: _____
- Health care information in my medical records for the date(s) _____
- Other (Labs, X rays, bills, etc.) _____

Specific Release Information- Required for release

This medical release (Please initial) _____ **MAY** **MAY NOT**
Disclose health care information regarding the testing, diagnosis, and treatment for:

- | | |
|---------------------------------------|--------------------------------|
| * HIV (AIDS Virus) | *Sexually Transmitted Diseases |
| * Psychiatric disorders/mental health | *Drug and/or alcohol use |

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). This authorization may be revoked in writing at any time except to the extent already relied upon, and will expire in 90 days unless previously revoked. I understand I may not be able to revoke this authorization if its purpose was to obtain insurance. Once health care information is disclosed, the person or organization that receives it may disclose it as allowed by law.

Patient or legally authorized individual signature

Date

Time

Printed Name if signed on behalf of the patient

Relationship (Parent, legal guardian, etc.)