AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (1 OF 2)

Lake Washington Vascular, 1135 116th Ave NE, Suite 305, Bellevue, WA 98004 | Phone: (425)453-1772 | Fax: (425) 453-0603

This Release of Information form gives us your permission to share your or request your health information. Please see the back of this form for a guide to filling it out correctly. Failure to follow instructions can result in a processing delay.

1. PATIENT INFORMATION

Patient Name (Last, First, Middle)_____ **Date of Birth**_____

Address_____

Best Contact Number_____ **My Provider at LKWV**_____

2. RELEASE MY RECORDS FROM (SELECT ONLY ONE)

☐ **Lake Washington Vascular**

☐ **Person/Facility**_____ **Ph. Number**_____ **Fx. Number**_____

Address_____

3. SEND MY RECORDS TO (SELECT ONLY ONE)

☐ **Lake Washington Vascular**

☐ **Person/Facility**_____ **Ph. Number**_____ **Fx. Number**_____

Address_____

4. PURPOSE FOR RELEASE (SELECT ONE)

☐ **Forwarding records to referring provider**

☐ **At the request of the request or the patient/ patient representative**

☐ **Other (please specify)**_____

5. RECORDS BEING SENT

☐ **Clinic Notes and Vascular Lab Reports**

☐ **Complete Chart**

☐ **Other (please specify)**_____

6. SELECT A PICK-UP OPTION IF RECORDS ARE FOR PATIENT REQUEST (SELECT ONLY ONE)

☐ **Pick-up in office**

☐ **Send through the Patient Portal**

☐ **Send through the mail**

***NOTE**: If you were an inpatient or had a surgery at a hospital, these records are processed by the respective hospitals.*

Overlake Medical Center - Medical Records	(425) 688-5643
EvergreenHealth - Medical Records	(425) 899-1920

7. MY RIGHTS AND AUTHORIZATION (PLEASE READ COMPLETE STATEMENT)

I understand that I have the right to revoke this authorization at any time, except for any actions already taken, and such revocation must be made in writing.

I understand that the information provided above is entirely voluntary. If I choose not to sign or revoke this authorization, Lake Washington Vascular will provide me with treatment and seek necessary payment for services. **However, I must sign this authorization form to participate in a research study or receive care when the purpose is to generate healthcare information for a third party.**

I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled. Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

I understand that this authorization will automatically expire within 90 days of being signed. If you prefer to have this authorization expire before the 90-day period, please indicate the expiration date.

NOTE: By signing below, you acknowledge and consent to the release of your records as described above.

Patient Signature_____ Date_____

Patient Representative's Signature_____ Date_____

Relationship to Patient

☐ Parent ☐ Legal Guardian* ☐ Medical Power of Attorney* ☐ Executor of Estate*

**Please attach any legal documentation if you are the Legal Guardian, Medical Power of Attorney, or Executor of Estate.*

PLEASE PROVIDE A COPY OF YOUR GOVERNMENT-ISSUED PHOTO ID

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (2 OF 2)

Lake Washington Vascular, 1135 116th Ave NE, Suite 305, Bellevue, WA 98004 | Phone: (425)453-1772 | Fax: (425) 453-0603

1. **PATIENT INFORMATION** - Print the patient's name, date of birth, address, best contact number, and the LKWV provider they are seeing.

2. **RELEASE MY RECORDS FROM** - Select **Lake Washington Vascular**. If we are requesting your medical records from another provider or facility, please select **Person/Facility** and provide the name, phone number, fax number (if known), and the address. This information helps us send or retrieve your records efficiently.

3. **SEND MY RECORDS TO** - If we are the recipient of your records, select **Lake Washington Vascular**. If we are sending your records, select Person/Facility and provide the name, phone number, fax number (if known), and the address. This information helps us retrieve your records efficiently.

4. **PURPOSE FOR RELEASE** - Please let us know the reason that this form is being filled out.

5. **RECORDS BEING SENT** - Please let us know if you would like specific records pertaining to your visits with us, or if you would like you complete chart records sent (This information includes billing information).

6. **SELECT A PICK-UP OPTION IF RECORDS ARE FOR PATIENT REQUEST** - If you are requesting your own records, please let us know how you would like to pick them up. This ensures that your records are ready for you to pick-up or sent to you as soon as we process this request.

If this document is not signed by the patient, documentation may be required to prove authority to sign on behalf of the patient. Please read the information below.

AUTHORIZED PATIENT REPRESENTATIVE FOR PATIENTS NOT COMPETENT

A personal representative is an individual who may act on behalf of a patient when the patient lacks the decision-making capacity to make health care treatment decisions. The personal representative may need legal documentation to demonstrate authority to sign for the patient. A member of one of the following order of priority: (a) the appointed guardian of the patient, if any; (b) the individual, if any, to whom the patient has given a durable power of attorney that includes the authority to make health care decisions; (c) the patient's spouse or registered domestic partner; (d) children of the patient who are at least eighteen years of age; (e) parents of the patient; and (f) adult brothers and sisters of the patient.

Please send your completed **Authorization to Release Patient Health Information** form by mail, patient portal, fax, or bring it in person.

ADDRESS:	Bellevue Clinic 1135 116th Ave NE, Suite 305 Bellevue, WA 98004	Kirkland Clinic 12333 NE 130th Lane, Suite 425 Kirkland, WA 98034
Requests For:	Medical Records - Fax to (425) 453-0603 or call (425) 453-1772 and ask to be transferred to the HIM department. Billing Records - Please call New Directions at (425) 367-6075.	