AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

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

This Authorization gives us permission to share your health information with specified family member(s) or any other provider you would like us to send you health information to. 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. RECORDS TO USE OR DISCLOSE

I authorize Lake Washington Vascular to use or disclose the following health information (check all that apply)

- ☐ **Discharge Instructions**
- ☐ **Office Visits**
- ☐ **Procedure Notes**
- ☐ **Vein Clinic Notes**
- ☐ **Vascular Lab Reports**
- ☐ **Lab Results**
- ☐ **Radiologic Imaging**
- ☐ **Appointment Information**
- ☐ **Billing Information**
- ☐ **All of my patient records**

3. PERSON OR PROVIDER TO DISCLOSE INFORMATION TO

Lake Washington Vascular may disclose the above health information to the following recipient

Name (or Title)_____ **Ph. Number**_____ **Fx. Number**_____

Address_____

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

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to Lake Washington Vascular.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that this authorization will expire 90 days from the date signed unless Lake Washington Vascular receives a written revocation as outlined above.

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