AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (1 OF 2)

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

This Authorization for Release of Health Information Form gives us your permission to share or request your health information. Please see the reverse side of this form for instructions on filling out this form. Failure to follow the instructions can result in a processing delay.

1. Patient Information

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

2. I Authorize Lake Washington Vascular To Release My Records To (If applicable, Referring provider not required)

Provider/Facility _____ **Ph. Number** _____ **Fx. Number** _____

3. I Authorize Lake Washington Vascular To Request My Records From (If applicable, Referring provider not required)

Provider/Facility _____ **Ph. Number** _____ **Fx. Number** _____

4. Purpose For Release (Select One)

- ☐ **Continuity of Care**
- ☐ **Transferring Care/Self Use**
- ☐ **Other (Please specify)** _____

5. Records Being Released or Requested (Select all that apply)

- ☐ **Clinic Notes**
- ☐ **Vascular Imaging**
- ☐ **Lab Reports**
- ☐ **Radiology Imaging**
- ☐ **All Records**
- ☐ **Other (Please specify)** _____

6. Select A Pick-Up Option If Records Are For Transferring Care or Self Use (Optional)

- ☐ **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 The Complete Statement Below)

I understand that if I choose not to release my records, I will sign this form as it is. This indicates that I declined to share my records.

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 this authorization remains valid for one year or until I revoke it in writing. Revocation does not affect information previously disclosed under this authorization. To revoke, I must provide a written revocation to Lake Washington Vascular.

☐ **Please check here if you do not wish to authorize the release of information (ROI).** By declining, your medical records can only be shared with the referring provider in accordance with continuity of care regulations. If you are self-referred or need to share records with another provider, we require your explicit consent on this form.

NOTE: By signing below, you acknowledge and consent to the release of your records or decline to release 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 | Phone: (425) 453-1772 | Fax: (425) 453-0603

Lake Washington Vascular is an independent practice, separate from the hospitals where our clinics are based. Therefore, we need your permission to share or access your medical records with any person or facility that did not refer you to our clinic

1. Patient Information - Print the following patient information: name, date of birth, address, best contact number, and assigned LKWV provider.

2. I Authorize Lake Washington Vascular To Release My Records To (If applicable, Referring provider not required) - If applicable, please provide the details of the provider or facility to which you consent for us to forward your medical records. If we already have your referring provider's information, list any additional providers involved in your care team with whom you would like to share your records.

3. I Authorize Lake Washington Vascular To Request My Records From (If applicable, Referring provider not required) - If applicable, please provide information for any provider or facility, other than your referring provider, from whom you would like us to request records. Include providers who have treated you for the same conditions we are seeing you for.

4. Purpose For Release (Select One) - Please select the purpose for this form: continuity of care, transferring care, self-use, or specify any other reasons.

5. Records Being Released Or Requested - Please select the records you would like us to release or request: clinic notes, vascular imaging, lab reports, radiology imaging, all records, or specify any other records.

6. Select A Pick-Up Option If Records Are For Transferring Care or Self-Use (Optional) - If you are requesting your own records, please let us know your preferred method of pick-up. This will ensure your records are ready for you to pick up or are sent to you as soon as we process your 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.	