RANDLE CLINIC
PO BOX 336 108 KINDLE RD
RANDLE, WASHINGTON 98377
PHONE (360) 497-3333 FAX (360) 497-5073

AUTHORIZATION TO RELEASE MEDICAL RECORDS

The patient or person authorized by law must complete and sign this form. There are separate and distinct portions of this authorization. Please read and fill out this authorization completely before signing your name.

(Please PRINT Name and Date of Birth) _____

I authorize _____to release a copy of my medical information to Randle Clinic

_____ _____
Information to be released from **Address**

_____ _____
Fax Number **City, State Zip**

- Individual signing authorization agrees to pay all charges as allowed by law with copying of record(s).
- Randle Clinic will not condition treatment for the patient if the patient or authorized person refuses to sign this authorization. The patient/individual may refuse to sign this authorization.
- I understand the privacy rule may no longer protect the Health Information released when it is disclosed to the recipient or to an authorized third party.

Please indicate by checking each space authorizing release of the specific medical information requested:
If Space(s) are not checked, information will not be released:

____ ER record: Date(s) _____or the Condition of: _____
____All hospital records including nursing, medication(s) and each and every report/document listed below.

____Billing Statements	____LAB/Pathology reports	____Nursing Notes
____MD reports (Dictation)	____X-Ray Imaging Reports	____Physical Therapy Notes
____MD orders	____X-Ray Films	____Social Worker Reports
____Most recent Five-Year History	____OTHER:_____	

Please indicate by initialing each space authorizing release of the specific medical tests below.

____STD Information ____HIV/AIDS Information ____Drug/Alcohol Information ____Mental Health Information

This authorization may be revoked at anytime by written, signed and dated notice to the address above. The only exception is if action has been taken in reliance upon the authorization unless revoked earlier.

Please provide an expiration date if no expiration is provided this authorization will expire 90 days from date of signature. Expiration date: _____

DATE_____ SIGNATURE OF PATIENT: _____

Signature of person authorized by law if not patient **:**_____(_____**)**
(Individual signing must be representing the patient) **Relationship**

Randle Clinic will not release requested medical information if this form is changed in any way or not completed as required by state and federal law.

4/09