MEMBER PLUS FAMILY HEALTH

Personalized Health Care for Bainbridge Island

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize and request that (Physician/Facility Name)_____

(Address) _____

_____

_____

release the following records and information to:

Member Plus Family Health
123 Bjune Drive SE, Suite 101
Bainbridge Island, WA 98110
FAX: 206-842-1877 or 844-238-6394

Patient requesting release of records:

Name _____

Address_____

City, State, Zip _____

Phone _____ Date of Birth_____

☐ Medical records from _____ to _____

☐ Special instructions _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug, and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I release the clinic and its staff from all legal responsibility or liability that may arise from the release of this information. This consent may be revoked by me at any time, except when action has been taken. This consent expires ninety [90] days from the date below. I understand that information used or disclosed Pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Authorized Signature _____ Date _____