



## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

<b>Name (Last, First, MI)</b>	<b>Client #</b>  _____
-------------------------------	------------------------------

<b>Street Address</b>	<b>City</b>	<b>State</b>	<b>Zipcode</b>
<b>Telephone (Area Code)</b>	<b>Social Security Number</b>		<b>Date of Birth (Mo,Day,Yr)</b>
<b>Kang Wen Provider</b>			<b>Date of Initial Clinic Visit</b>

**I hereby authorize the Kang Wen Community Clinic to release my protected health information that is contained in my patient records to the Recipient named below. I understand & acknowledge that this may include treatment for physical & mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses.**

<b>Name of Recipient:</b> <i>(please print)</i> _____
Street: _____
City: _____ State: _____ ZIP: _____ Telephone: _____
Reason for Disclosure: _____ (Reason for disclosure must be completed prior to processing)
Dates of Treatment Requested: _____

***This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire in 60 days from the date of authorization written below. I understand there is a service charge \$15.00 due at the time of service for releasing medical information. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your medical information is released, redisclosure of your medical information by the recipient may no longer be protected by law.***

\_\_\_\_\_  
*Signature of Patient/Patient's Personal Representative*

\_\_\_\_\_  
*Date Signed*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Relationship if not Patient*

\*\*If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.

**1111 HARVARD AVENUE SEATTLE, WA 98122**  
**206.322.6945, F206.388.5383**