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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

At Access Healthcare, PLLC we have the responsibility of ensuring that information regarding all patients remains confidential. This means that information regarding your medical condition, scheduling, billing, insurance issues, or any other protected health information as identified under HIPPA, cannot be released to other people, including family members, unless you authorize it in writing. Your patient confidentiality rights are protected under Chapter 70.02 of the Revised Code of Washington State.

If you would like to authorize another person to have access to the above mentioned medical information, please complete this release. Please note:

-  Only **2** people can be designated for this role (i.e., family member, friend, legal representative)
-  This authorization is valid until you cancel it in writing.

PLEASE CHECK EITHER DECLINATION OR AUTHORIZATION

Declination: I **DO NOT** wish to designate anyone at this time
 (If you decline designating Access Healthcare, PLLC *cannot* release information to **ANYONE.**)

Authorization: I **DO** wish to designate someone at this time

I, _____, Date of Birth _____, designate the following person(s) to be able to speak with Access Healthcare, PLLC staff on any claim of confidentiality in connection with the release of the information specified below.

 **1st Person Authorized**

Name _____ Phone _____ Home Cell
 Relationship _____
 All Medical Information Financial Information only Appointment information Only
 Information Specific to the Following Condition _____
 Other _____

 **2nd Person Authorized**

Name _____ Phone _____ Home Cell
 Relationship _____
 All Medical Information Financial Information only Appointment information Only
 Information Specific to the Following Condition _____
 Other _____

Signature _____ **Print Name** _____