

Orthopedic and Fracture Surgery
1632 116th Avenue NE, Suite C / Bellevue, WA 98004
Phone: (425) 462-9800 Fax: (425) 454-9143

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

I, _____, authorize Bellevue Bone & Joint Physicians to release my records to :

I AUTHORIZE THE FOLLOWING INFORMATION TO BE RELEASED:

- All treatment
- All billing information
- MRI
- X-ray
- Treatment notes
- Op-reports
- Other _____

PURPOSE FOR WHICH DISCLOSURE IS BEING MADE:

(Please check one of the following):

- Insurance
- Doctor
- Personal
- Attorney

PATIENT AUTHORIZATION:

I understand my records may be protected under federal and state confidentiality regulation and my express consent may be required to release any health care information relating to testing, diagnosis, and / or treatment for HIV (AIDS), sexually transmitted diseases, mental illness, or mental health treatment and / or alcohol abuse treatment. I hereby specifically authorize you to release all information relating to such diagnosis, testing or treatment.

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits. I may revoke this authorization in writing. I understand that once the health information reaches the noted recipient, that person or organization may re-disclose the information, and at that time it may no longer be protected under privacy laws.

REASONALBE FEE:

As a courtesy, your first request for Bellevue Bone & Joint records will be provided to you free of charge. This does not include outside records from other physicians.

- If you are requesting information for another physician to help you with further treatment, we can mail or fax the information directly to the physician at no charge.
- State law provides that a health care provider may charge a reasonable fee. There is a \$23 clerical fee per request, plus \$1.02 per page for the first 30 pages, and \$.78 per page thereafter. Please allow 5 business days for your record copying request.

Patient Signature _____ Date Signed _____

(This authorization will expire 90 days from the date signed)