



ORTHOWASHINGTON

Authorization to Release Medical Records

Patient Instructions: Please complete each section below.

Patient Information

First Name: MI: Last:
DOB: Age:
Address:
City/State/ZIP: Phone:

Release Authorization

I authorize OrthoWashington to release the following medical records:

Documents: ☐ Chart Notes ☐ Lab Work ☐ Operative Reports ☐ MRI Reports ☐ All Records
☐ Other:
Date Range: Body part(s) for the above records:
Send via: ☐ FAX to: ☐ US Mail ☐ I will pick up
☐ Email to:

Imaging: ☐ X-ray ☐ MRI Imaging **Format:** ☐ CD ☐ Flash Drive ☐ Email (enter address below)
Send via: ☐ Email to: ☐ US Mail ☐ I will pick up

Records are to be Released to:

Name/Company:
Address:
City/State/ZIP:
Phone:

Agreement

I understand the following:

1. I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
2. This authorization expires 90 days from the date of signing.
3. Once the above information is disclosed, it may be disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
4. Authorizing the use or disclosure of the information identified above is voluntary. I need to sign this form to ensure healthcare treatment.
5. A copy of this authorization shall have the same force and effect as the signed original.

Signature of Patient or Guardian*: Date:

Print Name:

☐ Patient is a minor

*If signed by Guardian, please indicate relationship to the Patient:

Return this completed form to:

OrthoWashington
12707 – 120th Avenue NE • Suite 203
Kirkland, WA 98034

Phone: 425-820-1221
Fax: 425-821-9362
Email: records@orthowashington.com