MILL CREEK OB|GYN
Specialists in Women's Healthcare

15808 Mill Creek Blvd ∞ Suite 200 ∞ Mill Creek, WA 98012 ∞ (425) 673-3420 ∞ Fax (425) 673-3423

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:

_____

(Previous Name): _____Date of birth: _____

Information to be released from:

Provider name/Organization: _____

Address:

_____

Phone: _____ Fax: _____

Information to be disclosed:

Complete OB/GYN record

OB/GYN records from the last 2 years

Other: _____

Unless otherwise checked below- complete record will be sent

HIV / AIDS Virus

Sexually Transmitted Diseases

Mental Health/Psychiatric Disorders

Drug, Alcohol Abuse/treatment

Please mail records to:

Mill Creek OB/GYN
15808 Mill Creek Blvd.
Suite 200
Mill Creek, WA 98012

Or fax:
(425)673-3423

This authorization will remain in effect:

Until I revoke in writing.

From the date of this authorization until _____ day of _____, 200____.

If no date is indicated, this authorization will expire in 6 months.

I hereby authorize the Practice to use or disclose to the recipient my health information for the term of this Authorization for the following specific purpose(s): ("At the request of the patient" is sufficient if the patient is initiating this Authorization).

Signature of patient or representative: _____

Date:

_____