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 to:

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

Records Released by:

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: ____