

## Consent for Release of Healthcare Information

I, \_\_\_\_\_ (Check one of the following)  
(Name of Patient or Guardian)

Patient                       Legal Guardian for Patient       Next of Kin

Patient's Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Authorize

Name: \_\_\_\_\_

Fax # (Required): \_\_\_\_\_

Address: \_\_\_\_\_

Alan Simons, ARNP (425) 451-4422 Fax (425) 449-5934  
1601 116<sup>th</sup> Ave NE, Suite 102 1836 Westlake Ave N Suite 203  
Bellevue, WA 98004 Seattle, WA 98109

### To Release the Following Information Contained in the Patient's Medical Records:

All Records and Reports                       Summary of Medical History and Treatment

Laboratory Test Reports                       Radiology Reports

Other: \_\_\_\_\_

Exchange Authorized Information on the Phone

### Must initial at least Mental Health Information Specific Authorization below. Plus others that apply:

Mental Health Information                      I understand that my records may contain  
Client Initials \_\_\_\_\_ information regarding diagnosis or treatment for mental health  
issues. I give my specific authorization for these records to be  
released.

Alcohol and Other Drugs                      I understand that my records may contain  
Client Initials \_\_\_\_\_ information regarding diagnosis or treatment for alcohol and  
other drug abuse. I give my specific authorization for these  
records to be released.

HIV/AIDS/Sexually Transmitted Diseases                      I understand that my records may contain information  
Client Initials \_\_\_\_\_ regarding testing, diagnosis, or treatment of HIV/AIDS, or of  
sexually transmitted diseases. I give my specific authorization  
for these records to be released.

### To:

Name: \_\_\_\_\_

Fax # (Required): \_\_\_\_\_

Address: \_\_\_\_\_

Alan Simons, ARNP (425) 451-4422 Fax (425) 449-5934

Consents may be revoked at any time except to the extent already relied upon, and unless revoked earlier by written notice filed by Alan Simons, ARNP, will expire in 90 days.

Patient/Guardian \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Witness Name/Title \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_