Tatyana M., MSN, ARNP, DClariT Medical & Esthetics Clinic LLC.
4317 Factoria Blvd. SE Suite C, Bellevue WA 98006 Phone: 425.444.8282 Email: tatyana@dclarity.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ DOB: _____
Previous Name (if any): _____ Phone: _____
Are you authorizing the release of your own records? □ Yes □ No
If not, what is your name and relationship to the patient?
Name: _____ Relationship: _____

Information to be released by:
Organization: _____
Name: _____
Address: _____
Phone: _____
Fax: _____

Information to be released to:
Organization:
Name: _____
Address: _____
Phone: _____
Fax: _____

Information to be released: *please check all that apply*
□ Complete Chart Record (This is limited to the two (2) most current years of information including Laboratory, X-ray, and Pathology Reports, but does not include billing information)
□ Health Care Information in my medical record relating to treatment/condition OR for the dates of:
_____

Billing Records:
□ All Records (This is limited to the two (2) most current years of information)
□ For the treatment/condition OR dates of: _____

Uses and Disclosures requiring specific authorization: Unless specifically **EXCLUDED** this authorization of Health Information may include documentation regarding the referral, diagnosis and treatment information relation to: ☐ HIV/AIDS □ Sexually transmitted Disease □ Mental Health or Illness □ Drugs and/or Alcohol abuse □ Reproductive Care (Minors only)

Purpose for which disclosure is being made:
□ Concurrent Care □ Transfer of Care □ Insurance □ Personal Use

My Rights:
I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do it in writing and present my written revocation to Tatyana M., ARNP, DClariT Medical & Esthetics Clinic. If information has already been released based on this release, the revocation will not apply to that information. I understand 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. I understand that one the information is disclosed, federal privacy laws or regulations may not protect the information and the recipient may re-disclose it.

I authorize release of my medical records, as described above. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment, however I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party.

_____ _____
Signature of patient or Legal authorized representative Date

Expiration: 30 days after the date that it is signed.