SNOQUALMIE VALLEY CLINIC

<u>AUTHORIZATION FOR RELEASE OF INFORMATION</u>

1,	B1	rui date		
(Please print full name and any other name	ne records may be under)			
	Snoqualmie Valley Cl D Thomas Balch, AR PO Box 2013 38700 SE River S Snoqualmie, WA 98 (425) 888-2299 Fax#	NP Marybeth La T 065	ambe, MD	
to release information contained i	n my medical records to):		
Name		Phone		
Address	City	State	Zip Code	
Information to be disclosed for				
	Reason			
• •	press consent is required to release any health care information relating to			
testing, diagnosis and/or treatmen psychiatric disorders and/or ment diagnosed or treated for HIV, sex or drug and/or alcohol use, you ar relating to such diagnosis, testing	al health, or drug and/or ually transmitted disease e specifically authorized	alcohol use. If I hes, psychiatric disc d to release all hea	ave been tested, orders, mental health, lth care information	
EXCLUSIONS: IDENTIFY ANI <u>DO NOT</u> WISH RELEASED:	SPECIFY PORTIONS			
I understand that my records are protected un written consent unless otherwise provided for medical condition and treatment Snoqualmie V anytime, except for the action already taken, a without prior revocation, will automatically ex	in the regulations (42 CFR Part2 Valley Clinic. I understand that I nd that such revocation must be). Staff from my provided have the right to withdra in writing. Further, I unde	r listed above may discuss my w this authorization at	
I understand that I do not have to	sign this authorization i	n order to receive	Health Care treatment.	
Signed	Printo	Printed Name		
Date F	Relationship if other than Patient			