Kinwell

AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION 1: Patient Information	
Name (Last, First, Middle Initial)	Date of Birth
Other Names Used (if applicable)	
Please indicate the purpose(s) of the request: ☐ **Continuing Care** ☐ **Transfer of Care** ☐ **Personal Use** ☐ **Legal** ☐ **Insurance** ☐ **Disability** ☐ **School** ☐ **Other (specify):**	
Information to be obtained or disclosed (including dates, if applicable.) ☐ **Office Visits** ☐ **Labs** ☐ **Procedure Reports** ☐ **Hospital or Discharge Summary** ☐ **Other (specify):**	
I specifically <u>authorize</u> the release of the following health information (select all that apply): ☐ Sexually Transmitted Infections (incl. HIV/AIDS) ☐ Mental Health/Treatment ☐ Reproductive Care ☐ Drug/Alcohol Diagnosis/Treatment ☐ Genetic Testing Information	
This authorization expires 180 days from the date signed unless another date or event is indicated here:	

SECTION 2: Person or organization authorized	
I authorize Information Released FROM:	**I authorize Information be Released TO:**
Organization/Recipient	*Organization/Recipient
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone # / Fax #	Phone # / Fax #
*If this release is to authorize sharing health information with a family/friend, please list their name(s) and relationship to you.	

SECTION 3: Signature

I have read and understand the following statements about my rights:

- I may cancel this authorization at any time before the expiration date or event noted above by notifying Kinwell in writing (600 Stewart St. Suite 800, Seattle, WA 98101). The cancellation will not affect any information either received or given by Kinwell before the cancellation notice was received.
- I am not required to sign this form to receive services or treatment. If I do not sign this form, Kinwell may not release my information to any person or organization except those needed to determine my continued coverage, eligibility, or as allowed by law.
- Any disclosure of information has the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.
- The Kinwell Notice of Privacy Practices is available at the clinic or online at www.kinwellhealth.com

______________________________ ______________________________ ________

Signature of Patient/ Legal Representative   Printed Name   Date

____ __________________

If signed by Legal Representative, relationship to patient   Phone Number

Fax this form to (509)459-6392 or email to roi@kinwellhealth.com.