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 authorize 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:	**Please Send/Share my Records TO/WITH:**
Organization/Recipient	Organization/Recipient
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone #	Phone #
Fax #	Fax #

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 (224 Westlake AVE N Suite 100 Seattle, WA 98109). 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.
- Kinwell's Notice of Privacy Practices is available upon request at the clinic or: www.kinwellhealth.com

Signature of Patient / Legal Representative	Printed Name	Date
If signed by Legal Representative, relationship to patient		Phone Number