

# Issaquah Medical Group

## MEDICAL RECORD RELEASE FORM

\*Please allow up to four weeks for copy & release of medical records. If records are offsite, copying may take longer.

### Patient Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Former Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Request & authorization: (Name & address of clinic records are to be sent from. MUST BE COMPLETED)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To release medical information to: (Name & address of clinic records are to be sent. MUST BE COMPLETED)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Information to be released:

\_\_\_\_\_ Entire medical record (IMG only) PERSONAL COPY 2 YRS WITHOUT CHARGE

\_\_\_\_\_ Immunization record (No charge)

\_\_\_\_\_ Only medical records relating to the following: \_\_\_\_\_

\_\_\_\_\_ Previous doctors records (This information is not routinely copied & released. If we do have these previous doctor's records & you would like them you can request them here, but please note there will be a charge.)

### Patient Authorization:

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorder/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care relating to such diagnosis, testing or treatment.

\*Exclude the following information from the records released: (Please initial)

\_\_\_\_\_ Drug/Alcohol abuse/treatment/diagnosis

\_\_\_\_\_ Sexually transmitted disease

\_\_\_\_\_ HIV/AIDS diagnosis/treatment/testing

\_\_\_\_\_ Mental Illness or Psychiatric Treatment

### My Rights:

I understand that I do not have to sign this authorization in order to get health care benefits (treatment/payment or enrollment).

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 information for a third party.

I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to our patients. I understand that once health care information is disclosed, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under Privacy Laws.

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Signature of patient or patient's legally authorized representative

Date

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED

## **NOTICE:**

Issaquah Medical Group keeps a record of the health care services provided to you. You may ask to examine and/or request a copy of your records. You may also ask to correct that record. Your record will not be released to others unless directed by you or compelled by law to do so. You may examine your records or get information about them at:

**Issaquah Medical Group, PLLC**  
**450 NW Gilman Blvd, Suite 201**  
**Issaquah, WA 98027**  
**Phone: (425) 391-0705**  
**Fax: (425) 391-9562**

Issaquah Medical Group will now be copying & billing all medical record requests. We will no longer be using a copy service. Payment is required BEFORE any records are sent. Copying of medical records for the purpose of a referral or medical necessity (from clinic to clinic) will be at no charge.

### **The new costs for medical records copying will be as follows:**

A \$22.00 clerical fee will be charged to any non-patient's representative, with an additional \$0.96 per page for the first 30 pages & \$0.73 per page for all additional pages. Any patient requesting records will not be charged the clerical fee.

When transferring medical records from doctor to doctor they can request up to the most recent 2 years at no cost. Any records past that should be requested by the patient and there will be a charge. See prices above.

Immunization records are always free of charge.

We will only mail record requests for patients, lawyers and insurance companies. We can fax or mail records to other doctor's offices. This is to insure the privacy of your medical records.

The above information is considered sufficient for continuity of care treatment. Due to the time and cost involved in reproducing this information, you will be CHARGED (if applicable) at the rates set by the state of Washington. If you do request this information, you will be contacted by IMG to arrange payment (if applicable).

The schedule of charges is created and regulated by the Washington State Uniform Health Care Information Act, RCW 70.02, Section 102 (12), and an authorization does not have to be honored until the fee is paid. (Please note changes effective 01/01/08)