GPS
GERIATRIC POST-ACUTE SPECIALISTS
The Direction You Want To Go

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# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____
Previous Name: _____ Social Security #: _____

I request and authorize Geriatric Post-Acute Specialists to release healthcare information of the patient named above to:

Name: _____
Street Address: _____
City, St, Zip: _____

This request and authorization applies to:

___ Entire Record or

| | | |
|---|---|---|
| ____Problem List | ____Progress Notes/Discharge Summary | ____History/Physical Exam |
| ____Medical List | ____Immunization Record | ____List of Allergies |
| ____Xray/Imaging Reports | ____Xray/Imaging Films | ____Laboratory Results |
| ____EKG Reports | ____Genetic Testing Information | ____Other Diagnostic Reports |

____ UpDox Patient Portal/E-mail Address_____

I understand the information in my health record may include information related to Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea. It may also include information at behavioral or mental health services, and treatment for alcohol and drug abuse.

____Yes, I consent to the release of this information. ____No, I do not consent to the release of this information.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that 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. Unless otherwise revoked, this authorization expires upon completing of this request or upon the following date: _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to ensure treatment, I understand that I may inspect of copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

_____ _____
Signature of patient or legal representative Date

_____ _____
Relationship to patient if legal representative Witness