Seattle Roots
Community Health
Home of Carolyn Downs Family Medical Center
& Country Doctor Community Clinic

RELEASE OF INFORMATION

FOR DISCLOSURE OF MEDICAL INFORMATION

Patient Name:		**MRN:**
PCP:	**SSN:**	**Birthdate:**
This is to authorize information specified below to be released by:		
And be sent to:		

INFORMATION TO BE DISCLOSED

Summary of Medical History/Treatment for the last two years will be released, unless otherwise specified.

I specifically authorize any information in the subject areas checked below to be released
(*complete records will not be sent unless purpose clearly demonstrates need*.)

☐ Laboratory/Diagnostic Tests	☐ Mental Health Illness, treatment, and/or Assessment
☐ Sexually transmitted diseases	☐ Drug and/or Alcohol Treatment
☐ HIV/AIDS (infection and/or antibody status)	☐ Other (please specify):

Purpose or need for data:

I release Seattle Roots Community Health Staff and Counsel from legal responsibility that may arise from authorizing release of information. This authorization may be revoked at any time unless action has already been taken, or 90 days from this or upon the following conditions or events:

X

Signature (patient/parent/guardian/representative) *If signed by person other than patient, please provide reason and relationship to patient.*	**Date:**
	Witness:

REDISCLOSURE PROHIBITED: If this information has been disclosed from records whose confidentiality is protected by State or Federal Law, these laws prohibit making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by the State law.

MRN= Medical Records Number
PCP= Primary Care Provider
SSN= Social Security Number

RETURN TO:	**Country Doctor Community Clinic** **500 19th Avenue East** **Seattle, WA 98112** **P=(206) 299-1600 Fax=(206) 299-1608**	**Carolyn Downs Family Medical Center** **2101 East Yesler Way** **Seattle, WA 98122** **P=(206) 299-1900 Fax=(206) 299-1906**