UNIBE Care Family Medicine

13100 Military Road S.
Suite #1 & 2
Tukwila, WA 98168
(206)242-7333

MEDICAL RECORDS RELEASE/REQUEST

1. I, the undersigned, hereby authorize _____to release information specified below from the Medical Record of, _____
(Patient's Name)
Date of Birth_____ and SSN: _____

2. State the reason or purpose for the release of information_____

3. Information to be released:
_____ Copy of complete record (including drug/HIV/AIDS/any communicable disease, mental health, if any).

_____ Other: (please specify)_____

4. Release of information regarding deceased individuals:
If the patient is deceased, a relative authorized by Washington State, or administrator or executor of the estate must sign the authorization. Therefore provide a copy of death certificate or copy of the legal document appointing the administrator or executor.

5. Release of information regarding minors:
a). A parent of a patient who is a minor (less than 18 years) must sign the release form.
b). If no parent is available, the legal guardianship or representative must accompany this release.
c). Records may be released to a minor if the patient is emancipated and the emancipated minor signs his/her own release. Examples of an emancipated minor includes, but is limited to; a minor on active duty with U.S. armed forces, a pregnant minor, or a minor 16 years or older who resides separate and apart from the child's parent/guardian, or is self-self-supporting and managing his/her own financial affairs.

6. The above information may be released to or from (name and address):

Information to be released TO:	**Information to be released FROM:**
UNIBE Care Family Medicine Name of Recipient	Name of Recipient
13100 Military Rd S Suite #2 Address	Address
Tukwila/WA/98168 City/State/Zip	City/State/Zip
206-242-7333/206-242-7335 Phone/Fax	Phone/Fax

7. I understand that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Washington State Board of Medical Examiners.
8. I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law.

Expiration: This authorization expires: _____ (insert applicable date MM/DD/YY). I understand this authorization will expire 90 days from the date signed if no specific expiration date is indicated.

Date:_____ Signature:_____

_____ _____
Qualified Personal Representative Relationship to Patient

Type of Identification (please circle one): Driver's License ID card Military ID Bank card w/photo Other:__