AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

SSN: _____ Previous Name: _____

I hereby request and authorize _____ to release health care information of the patient name above for the purpose of my continuing medical care to:

Dr. Estelle Yamaki

2319 SW 320th St

Federal way, Wa 98023

Phone: 253-927-5053 Fax: 253-927-6911

This request and authorization applies to:

____ Health care information related to the following treatment, condition or dates of treatment

____ All health care information

____ Other:

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment of HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

I understand and authorizing the use or disclosure of the information identified above is voluntary. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be re-disclosed by the recipient.

I understand that this authorization is valid for 90 day's, however, I may revoke this authorization at any time by notifying Dr. Yamaki's office and completing a Revocation of Authorization form. I understand that any revocation will not apply to information that has already been released in response to this authorization.

_____ _____

Signature of patient or patient's authorized representative Date

Relationship or status if signed by anyone other then the patient: _____