ARIA HEALTH GROUP

# PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

**Patient:** _____ _____ _____

(First Name) (Middle Initial) (Last Name)

**Date of Birth:** _____

Aria Health Group is authorized to( check desired choice):

**Furnish to:** _____

**Receive from:** _____

For the Purpose of: **Medical Care**

☐ I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:

1. Two recent chart notes,
2. Past two years of laboratory reports,
3. Past five years of radiology reports,
4. All pathology reports.

I release Aria Health Group, and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Aria Health Group, provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

**This Authorization expires on** _____ *(Optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.*

_____ _____

Patient Signature (Parent's Representative if minor) Date

_____ _____

Witness Signature Date

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BELLEVUE, WA 98004
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