

**HIPAA**  
**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

**Patient Name** \_\_\_\_\_  
*List all names used*

**Date of Birth** \_\_\_\_\_ **Social Security Number** \_\_\_\_\_

I hereby authorize the use or disclosure of the above-named individual's health information as described below:

**Information to be released from:** \_\_\_\_\_  
*Name of designated Facility or Provider*

\_\_\_\_\_  
*Address, City, State, Zip*

**Information to be sent to:** **James, Sanderson & Lowers**  
307 29<sup>th</sup> St NE, Ste 101  
Puyallup, WA 98372-6718  
Phone: 253-445-3400 § Fax: 253-445-4425

**Information to be disclosed:** records@jsandl.com

- Entire Medical Record
- Entire Medical Record from \_\_\_\_\_ **To** \_\_\_\_\_  
*Date Date*
- All Itemized Billing Statements & CPT Codes
- All Itemized Billing Statements & CPT Codes from \_\_\_\_\_ **To** \_\_\_\_\_  
*Date Date*
- All Films/X-rays/MRIs
- All Films/X-rays/MRIs relating to \_\_\_\_\_
- Other \_\_\_\_\_

Purpose for which disclosure is being made: *(Please check one of the following)*

- Attorney       Insurance       Doctor       Personal

**Patient Authorization:**

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. **Exclude** the following information from the records released; (Please initial)

\_\_\_\_\_ Drug/Alcohol abuse/treatment & diagnosis      \_\_\_\_\_ Sexually Transmitted Disease (STDs)  
\_\_\_\_\_ HIV/AIDS diagnosis/treatment/testing      \_\_\_\_\_ Mental Illness or psychiatric diagnosis/treatment

**My Rights:**

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it at which time it may no longer be protected under Privacy laws.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient, Guardian, or Authorized Representative)

Defendant's Attorney	Plaintiff's Attorney
Please Print Name	Please Print Name
Address	Address
City, State, Zip	City, State, Zip

WSBA# \_\_\_\_\_ WSBA# \_\_\_\_\_

Do you want a copy?  Yes  No      Do you want a copy?  Yes  No

**This authorization will expire 90 days from the date signed**  
**A copy of this authorization shall have the same force and effect as the original**