Sarah Woodall ARNP
roving body resting mind

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AUTHORIZATION FOR THE RELEASE AND EXCHANGE OF HEALTH INFORMATION

Records Copy Fees will be charged at Washington State Allowable

Patient Name:_____ DOB:_____

The person above hereby authorizes the release / exchange of information between Sarah Woodall, ARNP and:

Name of Provider or Facility:_____.
Address: _____.
FAX:_____. Phone_____.

The following information is to be released:

- Treatment History
- Treatment Summary / Discharge Plan
- Last Physical Exam
- Diagnostic Test Results (ECG, MRI, CT, Sleep Study, EEG)
- Emergency Room Visit
- Psychological/Neuropsychological Testing
- Individual Education Plan / School history
- Medication list and history
- Other

The information is to be released for the following reason:

_____

I understand that my records are protected under the Federal and State Confidentiality Regulations, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event the consent expires in 90 days unless I renew it. If ongoing exchange of information is desired, please indicate below. I further acknowledge that this information to be released was fully explained to me, and this consent is given of my own free will. This authorization will expire one year from the date I sign it.

_____
Signature of Patient Date

_____
Signature of Parent or Guardian

PROHIBITION ON RE DISCLOSURE

"This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42CFR, Part 2) prohibit you from making further disclosure of it without the written consent of the person to whom it pertains, or others permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose."