

**Dr. Roger Shelton**  
18012 73rd Ave W  
Edmonds, WA 98026  
rogershelton@comcast.net

**AUTHORIZATION FOR RELEASE OF INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Information to be released from:**

Dr. Roger Shelton  
18012 73rd Ave W  
Edmonds, WA 98026  
rogershelton@comcast.net

<b>All Records</b> _____
<b>Ultra Sounds/Images</b> _____
<b>Pap Results</b> _____
<b>Operations</b> _____
<b>Other:</b> _____

**Information to be sent to:**

\_\_\_\_\_  
Doctor or Name of Facility

\_\_\_\_\_  
Street Address, City, State and Zip Code

Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_ Fax (\_\_\_\_)\_\_\_\_-\_\_\_\_

**Specific Authorizations: (Because of the nature of our practice, these MUST be initialed to release records)  
(Please Initial Each)**

- \_\_\_\_ I specifically authorize the release of information pertaining to drug/alcohol abuse diagnosis or treatment.
- \_\_\_\_ I specifically authorize the release of information pertaining to mental health diagnosis or treatment.
- \_\_\_\_ I specifically authorize the release of to HIV/AIDS testing information.
- \_\_\_\_ I specifically authorize the release of genetic testing information.

**NOTICE**

Edmonds Women's Clinic and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

**MY RIGHTS**

- I understand this authorization is voluntary. Under no circumstances, however, am I required to authorize the release of mental health records.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to the clinic address above C/O Office Manager.
- Unless otherwise revoked, this authorization expires 12 months after the date of signing this form.
- I am entitled to receive a copy of this authorization

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Possible Copy Fees May Apply:  
\$23.00 Clerical Fee, \$ 1.04 for the first 30 pages and \$0.79 per page thereafter.**