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

All Records_____
Ultra Sounds/Images_____
Pap Results_____
Operations_____
Other:_____

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 is 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.