Kinwell

AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION 1: Patient Information	
Name (Last, First, Middle Initial)	Date of Birth
Other Names Used (if applicable)	
Please indicate the purpose(s) of the request: ☐ **Continuing Care** ☐ **Transfer of Care** ☐ **Personal Use** ☐ **Legal** ☐ **Insurance** ☐ **Disability** ☐ **School** ☐ **Other (specify):**	
Information to be obtained or disclosed (including dates, if applicable.) ☐ **Office Visits** ☐ **Labs** ☐ **Procedure Reports** ☐ **Hospital or Discharge Summary** ☐ **Other (specify):**	
I specifically authorize the release of the following health information (select all that apply): ☐ Sexually Transmitted Infections (incl. HIV/AIDS) ☐ Mental Health/Treatment ☐ Reproductive Care ☐ Drug/Alcohol Diagnosis/Treatment ☐ Genetic Testing Information	
This authorization expires 180 days from the date signed unless another date or event is indicated here:	

SECTION 2: Person or organization authorized	
I authorize Information Released FROM:	**Please Send/Share my Records TO/WITH:**
Organization/Recipient	Organization/Recipient
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone #	Phone #
Fax #	Fax #

Section 3: Signature

I have read and understand the following statements about my rights:

- I may cancel this authorization at any time before the expiration date or event noted above by notifying Kinwell in writing (600 Stewart St. Suite 800, Seattle, WA 98101). The cancellation will not affect any information either received or given by Kinwell before the cancellation notice was received.
- I am not required to sign this form to receive services or treatment. If I do not sign this form, Kinwell may not release my information to any person or organization except those needed to determine my continued coverage, eligibility, or as allowed by law.
- Any disclosure of information has the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.
- Kinwell's Notice of Privacy Practices is available upon request at the clinic or: www.kinwellhealth.com

_____ _____ _____

Signature of Patient / Legal Representative | Printed Name | Date

_____ _____

If signed by Legal Representative, relationship to patient | Phone Number