Bellingham Urology Group PLLC

John M. Pettit, M.D.
Vernon A. Orton, M.D.
Campbell F. Bryson, M.D.
Mackenzie Epler, PA-C
Eleni Zobolas, ARNP
340 Birchwood Ave., Bellingham, WA 98225
360-714-3400 F: 360-714-3402

AUTHORIZATION FOR BELLINGHAM UROLOGY GROUP PLLC TO USE OR DISCLOSE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security # (optional): _____

☐ **I hereby authorize the following Release of Information**

INFORMATION TO BE RELEASED BY:	**INFORMATION TO BE RELEASED TO:**
Bellingham Urology Group, PLLC	_____
340 Birchwood Ave	_____
Bellingham, WA 98225	_____
(360) 671-9197 FAX (360) 676-7730	Phone ( ) Fax ( )

This request and authorization applies to:

☐ Date(s) treatment was received: _____

☐ Consultation Report	☐ Laboratory Report	☐ Radiology
☐ Discharge Summary	☐ Operative Report	☐ Test Results
☐ Emergency Room Report	☐ Pathology Report	☐ Photographs, Videos, Digital or Other Images
☐ History and Physical	☐ Radiology Image Film	☐ Other_____

Purpose of Release:

☐Continuing/Transfer of Care ☐Insurance ☐Litigation ☐Personal Use ☐Other _____

This authorization expires on the following date, event or condition: _____.
If I do not specify any expiration date, event or condition, this authorization will expire in one year.
Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving a written notice to: Bellingham Urology Group, PLLC, and Attn: Medical Records, 340 Birchwood Avenue, Bellingham, WA 98225

Statement of Authorization:

- I understand that, except for research related treatment, Bellingham Urology Group, PLLC will not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Health Information Services (Medical Records). A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

*Patient or legally authorized individual signature: _____Date Signed: _____

***Under HIPAA you can be charged a "reasonable" fee for copying records. You may also be charged for postage if you ask that records be mailed to you. HIPAA allows 30 days for a provider to respond to your request for records, with one 30-day extension for good reason.**

FOR BELLINGHAM UROLOGY GROUP, PLLC USE ONLY

Medical records release collected by: _____ Date: _____
Medical records released by: _____ Date: _____ ☐Mail ☐Fax ☐Hard Copy