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 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 request and authorize: _____

To release healthcare information of the patient named above to:
 Bellingham Urology Group PLLC
 340 Birchwood Ave
 Bellingham, WA 98225
 P: (360) 714-3400 F: (360) 714-3402

This request and authorization applies to:

- Date(s) treatment was received: _____
- | | | |
|--|---|---|
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Test Results |
| <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Photographs, Videos, Digital or Other Images |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Radiology Image Film | <input type="checkbox"/> 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 requested by: _____ Date: _____
 Mail E-Mail Fax Hard Copy