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Permission to Release Medical Records and Information

Expires 90 days from date below and may be revoked by the patient orally or in writing at any time.

Patient Name: _____ **Date of Birth:** _____

Previous Name Used: _____ Phone Number: _____

Purpose of Release Request:

- Changing Doctors/Transferring Care
- Legal Reasons
- Consultation with Specialist
- Personal Use (Patient will be charged a fee)

Please Release my Medical Information **FROM**

Name of Physician/Clinic/Hospital _____

Mailing Address _____ City/State/Zip _____

Phone _____ Fax _____

Please Mail my Medical Information **TO**

Title (Physician, Attorney, Etc.) _____

Mailing Address _____ City/State/Zip _____

Phone _____ Fax _____

Please Send the Following Information:

- All Medical Records (Past 5 years)
- Medical Records From _____ to _____
- Specifically Requesting _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (Aids Virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. If signing for a person over 18 years of age, proof of guardianship, power of attorney or executor of estate must be provided. By signing below I acknowledge that my records may be re-disclosed by the recipient without the knowledge of Washington Park Medical Center and may not be protected in such an event.

Signature of Patient/Guardian

Date