AUTHORIZATION FOR THE RELEASE OF SPECIALLY PROTECTED CONFIDENTIAL INFORMATION

NAME:_____ DATE OF BIRTH: _____

I authorize release of information about my ■ Mental Health, ■ Chemical Dependency, ☐ STD/HIV/AIDS care in the following circumstances:

☐ The agency or provider named below requests information from Kwang-Hie Park, MD, PLLC.
☐ Kwang-Hie Park, MD, PLLC requests information form the agency or provider named below.
■ A mutual exchange of information between Kwang-Hie Park, MD, PLLC and the agency or provider named below.

MOM_____
DAD_____
OTHER_____
Phone:_____
Fax:_____

Kwang-Hie Park, MD, PLLC
901 Boren Avenue, Suite 1020
Seattle, WA 98104-3508
Phone: (206) 682-8900
Fax: (206) 624-1489

Purpose of Disclosure: ■ Continuing Care ☐ Legal ☐ Insurance ☐ At Patient Request for Patient Use

This authorization also applies to:
☐ Evaluation; ☐ Treatment Recommendation/Plan; ☐ Progress; ☐ Lab/Test Results; ■ Other - The above named person may call the office to schedule, confirm or cancel appointment(s) for me, they may also call and speak with provider/staff to discuss any concerns regarding medications, including refill requests.

For Service Dates, From _____ to _____

I understand that my records are protected under federal and state confidentiality laws and cannot be disclosed without my written consent unless otherwise provided for by law.

I understand that I do not have to sign this authorization in order to get health care except if I receive health care when the sole purpose is to create health information for a third party.

I understand that: a) I must revoke my authorization in writing and may do so by completing and signing such intent; b) If I revoke my authorization, it will not affect any actions already taken by Kwang-Hie Park, MD, PLLC based upon this authorization; and c) I may not be able to revoke this authorization if the purpose of it is to obtain insurance.

Once Kwang-Hie Park, MD, PLLC has disclosed health information, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information.

This authorization expires: _____

Minors - A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to, conception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

_____	_____	_____
Date	Signature of patient of patient's authorized representative	Relation to patient