Nancy E. Boyden, ARNP
Authorization for Release of Information of Medical Records
One Physician per Authorization

Patient Name: _____

Address: _____

SSN: _____ Date of Birth: _____

Name of Clinic or Physician: _____

Address: _____

Phone: _____ Fax: _____

I authorize the above named individual or organization to disclose the above named patient's health information as described below, to the following recipient: **Nancy E. Boyden, ARNP** **Copies of all responsive documents should be mailed to the following address: 7901 Skansie Ave., Suite 105 Gig Harbor, WA 98335 or faxed to (253) 432-4050,** for [ ]Continuation of Medical Care [ ]Transfer of Medical Care.

INFORMATION TO BE RELEASED:

_____ Current CBC, CMP, Cholesterol and any hormone testing. For men, last PSA
_____ Current History and Physical
_____ For women, current PAP report and mammogram report.
_____ Current colonoscopy report.
_____ All Records
_____ Other (please specify):_____

Information obtained from the above named individual or organization shall not be disclosed to anyone other than representatives of Nancy E. Boyden, ARNP to conduct a personal review of disclosed information to develop a plan of care. I understand that the information provided may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.

I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be re-disclosed.

REVOCATION: I have the right to revoke this release authorization at any time. The revocation must be in writing and delivered to Nancy E. Boyden, ARNP, at the address set forth above. The revocation will not apply to records and information that have already been provided.

EXPIRATION: This authorization will expire when the request has been filled.

PHOTOCOPIES OF THE AUTHORIZATION ARE VALID AND MAY BE USED IN LIEU OF THE ORIGINAL.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize to disclose and use my health information in the manner described above.

Patient/ Legal Representative Signature Date