Nickel Obstetrics & Gynecology

222 North J Street Suite A, Tacoma WA 98403 Phone (253) 572-4664 Fax (877) 795-9868

RELEASE OF HEALTH CARE INFORMATION

(Form A)

This form is used by the patient to authorize Nickel Obstetrics & Gynecology and Dr. Adam T. Nickel to release patient health care information to a designated employer or entity.

Date: _____/_______/______

Patient Name: ____ Date of Birth: ____________________

SS#: __________________________________ Previous Name: ____________________________________

I request and authorize Nickel Obstetrics and Gynecology, and Dr. Adam T. Nickel to release health care information to the entity listed below:

Entity Name: ____

Phone Number: ___________________________________ Fax Number: _____________________________

Address: ____

City: ______________________________ State: _________________ Zip:__________

Medical Information to be released:

- Full Medical Record
- Partial record: (please list specific records and dates of service)

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I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

____ ________________________________

Signature of patient or authorized representative Date

Relationship to signee: _____________________

This authorization expires 365 days after this request.