TIMOTHY A ROGGE MD ELIZABETH L ROGGE MS ARNP
FAMILY MEDICAL PSYCHIATRY
8105 166TH AVE NE SUITE 202 REDMOND WA 98052
HTTP://ROGGEPSYCHIATRY.COM/
OFFICE LINE 425-647-1225 FAX 425-861-1085

Authorization to Release Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization to:

Name: _____

Address: _____

Telephone: _____ Fax:_____

You may disclose to TIMOTHY A ROGGE MD or ELIZABETH L ROGGE MS ARNP the following health care information (check all that apply):

- ☐ All healthcare information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: _____
- ☐ Health care information in my medical record for the date(s): _____
- ☐ Other (e.g., X-rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- ☐ HIV (AIDS virus)
- ☐ Sexually transmitted diseases
- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use

Reason(s) for this authorization:

- ☐ Coordination of my healthcare.
- ☐ Other: _____.

This authorization ends:

- ☐ on (date): _____
- ☐ when the following event occurs: _____
- ☐ 90 days from the date signed.

II. My Rights

I may revoke this authorization verbally or in writing. If I do, it will not affect any actions already taken based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.
Once health care information is disclosed, the person or organization that receives it may re-disclose it.

_____
Patient or legally authorized individual signature Date

_____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

INITIAL HERE _____