Stephen E. Fuhs, M.D.
Carleton A. Keck, Jr. M.D.
William F. Wagner, Jr. M.D.
John A. Miyano, M.D.
Elizabeth S. Joneschild, M.D.

RECORDS RELEASE AUTHORITY

Date: _____ Dr. Name (SHSG)_____

I _____ hereby authorize the release of my medical records.
(print name**)**

TO or FROM (circle one) **Seattle Hand Surgery Group, P.C.**

_____

TO or FROM (circle one)

Provide Name & Address

1) First set complimentary if sent to Patient or Physician (must be filled out completely)

_____
_____
_____
_____
_____
_____

2) Second set subject to $23.00 record location fee plus $1.02/page for first 30 pages and $.78/page for additional pages. Pre-payment required.
RCW 70.02.010

_____
_____
_____
_____

Check one:

_____ The following health care information _____

_____ All written health care information; that identifies the patient or can readily be associated with the patient and relates to the patient's heath care, this will include all written health care information in our possession generated or ordered by Seattle Hand Surgery Group, P.C., also included will be health care information associated with drug and alcohol use, mental or psychiatric care, HIV status or diagnosis of AIDS, or other sexually transmitted diseases.

_____ Radiographs (x-rays) generated by Seattle Hand Surgery Group, P.C. First set sent to patient or physician office will be complimentary. Each additional set will cost $10 for each 8 x10, $15 for each 10 x 12. Pre-payment required.

Complimentary copying and mailing of records for patients are performed as a courtesy to our patients. Requests for records that exceed once every three (3) months will be charged at the rates stated above. Pre-payment required.

The release is subject to revocation at any time. The revocation is effective from the time it is communicated to the health care provider. If not revoked the release terminates *ninety (90) days* after it is signed in accordance with the Revised Code of Washington 70.02.030(6).

Signed: _____ **Patient's Date of Birth:** _____

Relationship if other than patient _____

Witness _____