<table>
<tr>
<td>Karen I. Fryberg
Tulalip Health Clinic
Medical Records
7520 Totem Beach Road
Tulalip, WA 98271
P: 360-716-4511
F: 425-259-8626</td>
<td>

AUTHORIZATION TO RELEASE MEDICAL RECORDS</td>
<td><u>For Clinic Use Only:</u>
☐ Records sent from Clinic
☐ Picked up/Received
☐ Mailed
☐ Faxed
Date received: _____________
Date Processed: ____________
Processed by: ______________</td>
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Please complete this form in its entirety so we can help you receive the information you are requesting.

1. **This authorization is voluntary. By signing below, I authorize Karen I. Fryberg Tulalip Health Clinic to fulfill the Authorization to Release Medical Records.**
   Patient Name: _____________________________________ Date of Birth: ___________________________
   Phone number: ___________________________
2. **The purpose or need for this disclosure is:**
   ☐ Personal Use ☐ Continuation of Care ☐ School ☐ Attorney ☐ Disability
3. ☐ Other Street Address: ___________________________ City/State/Zip: ___________________
   Phone: _______________________
4. **The information to be disclosed from my health record: (Check appropriate box(es))**
   ☐ Immunizations ☐ Entire Record (72 business hours)
   ☐ Well Child Exam ☐ Disability
   ☐ Dental Exam ☐ Other (specify): ______________________________________
5. **If you would like any of the following *sensitive* information disclosed, check the appropriate box(es) below:**
   ☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
   ☐ Sexually Transmitted Disease ☐ Mental Health (Other than psychotherapy notes)
   ☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

Executed this _______________ day of ____________________________________, 20________.

_______________________________________ _______________________________________
Patient/Guardian/Representative name (print) Patient/Guardian/Representative Signature

____
Relationship

I understand that this authorization is effective for one (1) year from the date of my signature, but I may revoke this authorization in writing any time by submitting the request to the Health Information Management Department.

Effective_______________________ and ending_______________________ (If Applicable)
(Month / Day / Year) (Month / Day / Year)