

**RAINIER ONCOLOGY
PROFESSIONAL SERVICES**

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize RAINIER ONCOLOGY PROFESSIONAL SERVICES to release healthcare information in the following way:

I authorize the information to be disclosed as specified below:

- On my voicemail/answering machine at home** _____ (specify phone #)
- On my voicemail/answering machine at work** _____ (specify phone #)
- To the following family member(s) or other person(s):**

Name	Relationship(eg Spouse, caregiver, son/daughter)	Phone #

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates:** _____

All healthcare information

Other: _____

In addition to above please check all that apply:

- Yes No I authorize the release of my Laboratory test dates
- Yes No I authorize the release of my Laboratory Results
- Yes No I authorize the release of my Prescription drug information
- Yes No I authorize the release of Medical Instructions or advice

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 120 DAYS AFTER IT IS SIGNED.