



WASHINGTON  
UROLOGY  
UROGYNECOLOGY  
ASSOCIATES, PLLC

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**Authorization for Washington Urology Associates  
to Obtain or Disclose My Health Care Information**

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Other name: \_\_\_\_\_

**I hereby request and authorize:**

Physician Name: \_\_\_\_\_  
Institutional Affiliation: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**To release my health care information to the following:**

Physician Name: \_\_\_\_\_  
Institutional Affiliation: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**This request and authorization applies to:**

\_\_\_\_\_ Health care information relating to the following treatment, condition, or dates of  
treatment: \_\_\_\_\_  
\_\_\_\_\_ All health care information  
\_\_\_\_\_ Other: \_\_\_\_\_

I understand that my express consent is required to release my health care information relating to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, drug or alcohol use. If I have been tested, diagnosed, or treated for any of the foregoing conditions, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Yes (please initial): \_\_\_\_\_ No (please initial): \_\_\_\_\_

**The reason for this release is:** \_\_\_ Referral/Pre-op \_\_\_ Moving \_\_\_ Insurance \_\_\_ Legal  
\_\_\_ Leaving Practice \_\_\_ Other: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient or legally authorized individual

Relationship (parent, legal guardian, personal representative, etc): \_\_\_\_\_

**This Authorization Expires 90 Days After It Is Signed**

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