**Gary Schuster, M.D.**

Broadway Sports and Internal Medicine

1600 116th Ave NE, Suite 202

Bellevue, WA 98004

(206) 215-2288 Phone

(206) 215-2289 Fax

**Authorization For Disclosure of Protected Health Information**

**List the phone numbers where we may leave detailed messages specifically for you:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ None\_\_\_\_

Home Mobile

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­ ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Other

With my signature below I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

**List the designated parties with whom we may leave messages (not doctors):**

**\_\_**This authorization will expire one year from the date signed by the patient or patient’s representative

\_\_This authorization is effective for the lifetime of the patient unless revoked in writing.

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NAME RELATIONSHIP NAME RELATIONSHIP

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NAME RELATIONSHIP NAME RELATIONSHIP

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NAME RELATIONSHIP NAME RELATIONSHIP

This authorization grants permission to the Designated Parties above to exchange my private medical information with Broadway Sports and Internal Medicine, Dr. Gary Schuster and any authorized representative thereof, without restriction in terms of content, purpose or means of transmission. This authorization includes, but is not limited to: making or confirming appointments; accession any and all x-ray, laboratory or test information; access to telephone communication and treatment plans; direct discussion of my health with my doctor or other provider; any have access to my financial information as it relates to my health.

* I understand that providing this authorization is voluntary
* I understand that my treatment cannot be conditioned on whether I sign this authorization
* I understand that it is my responsibility to notify my healthcare provider should I amend one or more of the Designated Parties listed above.
* I understand that once this information is disclosed to the Designated Parties, the released information may no longer be protected by federal privacy regulations.
* I understand that I may revoke this authorization at any time by notifying Broadway Sports and Internal Medicine in writing. If I do revoke the authorization, It will not have any effect on any actions taken by Broadway Sports and Internal Medicine prior to receipt of the revocation.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**