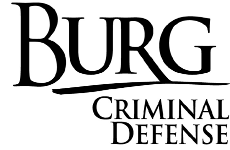

LAW OFFICES OF
GEOFFREY BURG, LLC

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PACIFIC BUILDING
720 3RD AVE • SUITE 2015
SEATTLE, WA 98104

RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Patient Name: ________________________ Date of Birth: ________________________

I, ___________________________, hereby authorize ____________________________ to release the following medical records information to The Law Offices of Geoffrey Burg, LLC, for the period of time beginning ______________ and ending ____________________.

Any and All Records Concerning These Subject Areas

☐ Drug/Alcohol Treatment
☐ Mental Illness/Mental Health Treatment

Specific Information to be Released (check all appropriate boxes):

☐ Summary of Medical History/Treatment
☐ Radiology Films
☐ Laboratory/Diagnostic Tests
☐ Emergency Room Records
☐ Radiology Records
☐ EMS/Paramedic Records
☐ Alcohol/Drug Screening Results
☐ Other:________________________

I understand that:

1. Information shall be released to the Law Offices of Geoffrey Burg, LLC.
2. Medical facility staff may discuss my medical condition and treatment with the Law Offices of Geoffrey Burg, LLC
3. My records are protected under Federal and State statutes and cannot be disclosed without my written consent unless otherwise provided for in regulations.
4. I may revoke this consent, in writing, at any time except to the extent that action has already been taken.
5. This authorization for release of medical information expires in 180 days, unless sooner revoked by me in writing.
6. A photocopy of this authorization shall have the same effect as the original.

_________________________________ _________________________________

Patient Name Date