



Release of Information

I request the transfer of the following medical records concerning _____ (name),
_____ (date of birth), in order to facilitate medical care with Dr. Chad Magnuson:

- Standard selection suggested by Dr. Magnuson
 - Acute and Chronic Problem List
 - Lab Flow Sheet and labs from the last 5 years.
 - Medication list
 - Most recent Health Care Maintenance Exam (physical)
 - Immunization records
 - Growth chart (for children)
 - ECG and spirogram if available
- Specific other records: _____
- I specifically request information not be released regarding the following condition(s):
 - Initials
 - _____ Drug abuse if any
 - _____ Substance abuse if any
 - _____ Psychological or psychiatric conditions if any
 - _____ AIDS/HIV, sexually transmitted infections if any

From:

To: Chad Magnuson MD
 17429 Vashon Highway SW
 P.O. Box 1450
 Vashon, WA 98070
 Phone: (206) 463-5401
Fax: (206) 686-5610 Preferred for all records as will be transferred to an EMR

x _____ Is Patient a Minor? Yes ___ No ___
 Patient's Signature Date

x _____ Relation to Patient _____
 Patient's Representative's Signature Date

IF YOU HAVE ANY DIFFICULTIES RECEIVING THIS FAX PLEASE CALL (206) 463-5401

PRIVILEGED AND CONFIDENTIAL INFORMATION:
 The information contained in the message is privileged, confidential or otherwise exempt from disclosure and is intended solely for the use of the individual(s) named above. If you are not an intended recipient, you are hereby advised that any dissemination, distribution or copying of this communication is prohibited. If you have received this message in error, please immediately notify the sender by telephone and immediately destroy the message. Thank you. Chad Magnuson MD