Sound Clinical Medicine PS
6718 144th Street NW • Gig Harbor, WA 98332 • (253) 857-6166

Authorization to provide Access to Healthcare Information

Patient Name: _____DOB:_____

Please list any person you will allow to have verbal and/or physical access to your Healthcare Information, to include treatment records and payment records.

Patients who are Minors:
A minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 or older), HIV/AIDS (if age 14 or older), drug and/or alcohol abuse (if age 13 or older), and mental health or illness (if age 13 or older).

I authorize that my Healthcare Information may be disclosed to:

Name:	Relationship:	Phone Number:

This Authorization will remain in place until you provide written cancellation of the Authorization to Dr. Wingren's office.

Signature of Patient: _____

Signature of patient/representative: _____

Date: _____