



Village Family Clinic & Wellness Center
317 NW Gilman Blvd., Suite 48
Issaquah, WA 98027
(425) 996-3396
www.villagefamilyclinic.com

RELEASE OF MEDICAL RECORDS

I hereby authorize: _____

To release all the medical records for patient: _____
(patient name & date of birth)

To: **Kristina Garrido, ARNP**
Village Family Clinic & Wellness Center, PLLC
317 NW Gilman Blvd., Suite 48
Issaquah, WA 98027

This release of medical records is for the purpose of continuity of care.

I understand that the records for care, treatment or medical services provided to me, and retained by you, may contain information regarding my mental health, STDs and drug use history. HIV-related information, including testing for HIV, and HIV-related illnesses or AIDS, and the results of these tests, may also be included in the records authorized for release.

I further understand that without this authorization, the releasing clinic would not be permitted to disclose this information, as indicated by law.

Patient/Guardian Signature Date Signed

If Guardian, please state relationship to patient: _____