AUTHORIZATION FOR RELEASE OF INFORMATION

NAME: Zoya Barnes **DOB:** 2/8/1977

Information to be released from:

Dr. Motiwala Dental Clinic & Implant Center
Park View Building, 2nd Floor
Road No.1, Near KBR Park, Jubilee Hill
Hyderabad – 500 033
Telangana, India

Information to be released (via Keais) to:

David J. Russell
Keller Rohrback L.L.P.
1201 Third Ave., Suite 3200
Seattle, WA 98101-3052

Copy Requested: Yes X *No*___

Shawn Q. Butler
Helsell Fetterman, LLP
1001 Fourth Avenue, Suite 4200
Seattle, WA 98154-1154

Copy Requested: Yes X *No*___

Information to be released:

☐ The most recent two years of pertinent information (Chart notes, labs, x-rays and special tests).

☒ **All medical and billing records.**

☒ Specific information: Any and all medical records in your possession as defined in RCW 70.02 et seq. of the Uniform Health Care Information Act, specifically RCW 70.02.0 10 (6), restated herein as follows: "... Any information, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a patient and directly relates to the patient's health care information. The term includes any record of disclosures of health care information." The health care information requested includes, but is not limited to, communications and records from other health care providers, telephone messages/logs, chart notes, narrative medical records, reports, notes, correspondence (including e-mail), memoranda, statements, hospital records, billing statements, medication prescription records, labs, special tests, written radiological reports, and radiographic studies (including x-rays, CT scans, and MRIs).

Purpose for which disclosure is being made:

☐ Insurance ☐ Doctor ☐ Personal

☒ Attorney and/or litigation to include redisclosure to consulting and other experts for litigation purposes.

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*Initial only if the following information is to be excluded from the records released:

_______ Drug/Alcohol abuse/treatment & diagnosis _______ Sexually Transmitted Disease

_______ HIV/AIDS diagnosis/treatment/testing _______ Mental Illness or Psychiatric diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: ______________________________ DATE: 12/30/2015

(Patient, Guardian*, or Authorized Representative*).

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED.