Authorization to Release Patient Health Information

West Seattle Natural Medicine Clinic
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Phone: 206-938-1393   Fax: 206-922-5322

PATIENT INFORMATION

Name: ____

Date of Birth: ____

INFORMATION TO BE RELEASED FROM WEST SEATTLE NATURAL MEDICINE CLINIC TO:

Other doctor/Facility: ____

Address: ____

Phone: _____________________________   Fax: ________________________________

INFORMATION TO BE RELEASED

Date Range: (from) _____________ (to) ___________ or

All Healthcare Information: ______________   or

Other (please specify such as “only labs”, “only last 2 years”, etc.) : _________________________

PATIENT RIGHTS/AUTHORIZATION

I understand that authorizing this disclosure of this patient health information is voluntary. I understand that unless expressly limited by me in writing, I am specifically authorizing the release of any sensitive medical information that may appear in my medical record including records for mental health treatment, pain management, sexually transmitted diseases, AIDS/HIV treatment, and substance abuse.

SIGNATURE

Patient Signature (or legal representative) _____________________________ Date: __________________

Relationship to patient, if not signed by patient: ____