Authorization to Release Patient Health Information

Seattle Integrative Medicine
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Patient Name: _____
Former Name (if any):_____
Daytime Telephone: (___)_____
DOB:_____

TO:	**FROM:**
Organization:_____	Organization_____
Address:_____	Address:_____
Phone_____	Phone_____
Fax:_____	Fax_____

TYPE OF RECORDS REQUESTED (Charges for copies may be applied)

Health care information related to a following treatment or condition:

_____

Laboratory/Diagnostic Test _____ Drug and/or Alcohol Abuse _____ X-Ray Films _____ Mental Health _____ Sexually Transmitted Diseases (HIV/AIDS) _____ Other _____

Purpose or Need for this information: Continuing Care_____ Copies for other use _____

Requesting Information to be Released **to**:

____ Laurie Mischley, N.D	____ Christian Dodge, ND
____ Marco Vespignani, N.D.	____ Samantha Evans, ND
____ Melissa McCarty, N.D.	____ Belle Minshall, ND

_____Other

Patient Rights: I understand that I have the right to revoke the authorization, in writing, at any time. I understand that a revocation is not effective when the recipient has already relied on the use or discloser of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. To revoke an authorization, I can write a letter to the person or entity holding the authorization, providing detail of the date and content of the original authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal law. I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize to release of patient health information to the above named person or organization.

Signature of patient _____ Date:_____

_____ _____ Authority to sign, if not the patient:_____

Authorized Personal Representative (Date) _____