

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Seattle Integrative Medicine
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info@seattleintegrativemedicine.com

Patient Name: _____

Former Name (if any): _____

Daytime Telephone: () _____

DOB: _____

INFORMATION TO BE RELEASED TO

Organization: _____

Doctor: _____

Address: _____

Phone/Fax: _____

INFORMATION TO BE RELEASED FROM

Organization: _____

Doctor: _____

Address: _____

Phone/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 _____

FOR THE PURPOSE OF:

Continuing Care _____ Copies for other use _____ Transfer of Care: _____

REQUESTING INFORMATION TO BE RELEASED TO:

____ Marco Vespignani, ND _____ Chris Holder, ND, LAc
____ Laurie Mischley, ND _____ Jason Allen, ND
____ Natalie Freedman, ND, PT _____ Melissa McCarty, N.D.
____ Rebecca Buettner, ND, LAc

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 disclosure 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 or Authorized Personal Representative (Date)
(A minor patient's signature may be required)

Authority to sign, if not the patient