

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

1.) Individual information:

Patient name: _____ SS#: _____ DOB: _____

2.) Information may be disclosed by:

Name of provider or organization releasing information: _____

Address: _____ Suite/Unit #: _____

City: _____ State: _____ Zip: _____

3.) Information may be disclosed to:

Name of person or organization to receive information: Lifespan Naturopathic Medicine

Address: 3442A California Avenue SW Suite/Unit #: _____

City: Seattle State: WA Zip: 98116

Daytime phone number: 206.400.7550 Fax number: 855.577.7375

4.) Please disclose the following information: (Check appropriate box. Copy fees may apply.)

- checkbox All records from the last _____ years.
checkbox Information from date _____ to date _____.
checkbox Email communication (please specify): _____
checkbox Other (please specify): _____

5.) Information is being disclosed for the following purpose: (Check only one box.)

- checkbox Attorney checkbox Insurance checkbox Doctor checkbox Medical Leave checkbox Personal checkbox Other: _____

Special Authorization:

Information released may include information on the testing, diagnosis, or treatment of HIV/AIDS, sexually transmitted infections, chemical dependency, and/or mental/psychiatric illness. Please initial here to indicate special authorization for the release of this specific information: _____ (initial)

Rights:

Generally, Lifespan Naturopathic Medicine and any other entity covered by the Health Insurance Portability and Accountability Act of 1996 may not condition treatment, payment, enrollment, or eligibility for benefits on whether an individual signs this authorization. This authorization may be revoked in writing at any time. Once the information that has been authorized to be released has been released, it may no longer be protected under health information privacy laws. If this authorization is revoked, it will not affect any actions already taken by Lifespan Naturopathic Medicine based on this authorization.

Signatures:

Patient/Guardian Signature: _____ Date: _____

Minor Signature (required if minor is aged 13-17 years): _____ Date: _____

This authorization expires 90 days from the date signed OR on the date or event indicated here: _____