NATUROPATHIC MEDICINE

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: Lifespan Naturopathic Medicine

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

City: Seattle State: WA Zip: 98116

3.) Information may be disclosed to:

Name of person or organization to receive information: ______________________________

Address: ______________________________ Suite/Unit #: ______________

City: ______________________ State: __________ Zip: ______________

Daytime phone number: ______________________ Fax number: ______________________

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

- ☐ All records from the last ________ years.
- ☐ Information from date ______________ to date ____________.
- ☐ Email communication (please specify): ______________________________
- ☐ Other (please specify): ______________________________

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

Attorney ☐ Insurance ☐ Doctor ☐ Medical Leave ☐ Personal ☐ 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: ______________________