Authorization for Release of Health Information

Patient Name_____ **DOB**_____ **Telephone**_____

Address_____ **City/Zip**_____

Please release information FROM:

Name_____

Facility_____

Address_____

_____

Phone_____ Fax_____

Please release information TO:

Lindsay Wais, ND

Absolute Wellness Clinic

465 Rainier Blvd. N. Suite A

Issaquah, WA 98027

Phone: (425)392-5321 **Fax: (425)837-3785**

Please specify the health information you authorize to be released:

- ☐ Labs ☐ All ☐ Specify _____
- ☐ Imaging Reports ☐ All ☐ Specify _____
- ☐ Chartnotes ☐ All ☐ Specify _____
- ☐ Other_____

The following information will not be released unless you specifically authorize it by initialing below:

_____ I authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment.
_____ I authorize the release of HIV/AIDS test results.
_____ I authorize the release of genetic testing information.

Absolute Wellness Clinic and many other health care institutions are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it might no longer be protected by state or federal confidentiality laws.

Unless otherwise revoked, this authorization expires 6 months after the date of signing this form. This authorization may be revoked at any time. The revocation must be in writing, signed by you or your guardian, and mailed or faxed to Absolute Wellness Clinic. The revocation will take effect when Absolute Wellness Clinic receives it, except to the extent Absolute Wellness Clinic or others have already relied upon it. You are entitled to receive a copy of this authorization.

_____ (initial) ***I acknowledge that I have read and understand the above statement.***

_____
Patient (or Parent/Guardian)

_____
If parent/guardian, print patient's name

_____
Print Name

_____
Relationship to Patient

_____
Date