

Institute of Complementary Medicine, PLLC
1600 E Jefferson Street Suite 603
Seattle, Washington 98122
Phone: (206)-726-0034

OFFICE ONLY: Date Sent: ____/____/____

Physician: _____

Authorization to Release Confidential Health Information

I Hereby Authorize:

Institute of Complementary Medicine

Or

Facility/Doctor's Name: _____
Address _____
City: _____ State: _____ Zip: _____
Phone # _____ Fax # _____

To Release:

Complete Chart Record (*does not include billing information or radiographic images*)

Chart Notes: All Specify

Labs/ Reports: All Specify

Billing Records: All Specify

X-rays / Radiographic Images (specify) _____

Other: _____

From the Health Records of:

Name: _____ Date of Birth ____/____/____

Daytime Phone: _____ ext: ____ Evening Phone: _____

Are you authorizing release of your own records? Yes No

If not, what is your relationship ? _____

Release of certain medical information requires a minor's consent. This applies to persons aged 13 to 17 for information pertaining to substance abuse and mental health information, or persons aged 14 to 17 for information pertaining to sexually transmitted diseases, HIV and AIDS. Other laws may apply.

To be Released To:

Institute of Complementary Medicine
1600 E Jefferson St. Suite 603
Seattle, WA 98122
Phone: 206-726-0034 Fax: 206-726-9434

Or

Facility/Doctor's Name: _____
Address _____
City: _____ State: _____ Zip: _____
Phone # _____ Fax # _____

For the Purpose of:

Concurrent Care Transfer of Care Other: _____

I understand that unless revoked this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.

Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to:

(Check the accompanying box(es) below to EXCLUDE the information from authorization)

substance abuse mental health conditions/psychotherapy sexually transmitted diseases HIV/AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.

I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing. I may call the Institute of Complementary Medicine 206-726-0034 to inquire about revoking authorization.

Patient's Signature: _____ Date: _____

Rep. / Guardian's signature: _____ Date: _____