

Institute of Complementary Medicine

1600 E. Jefferson St., Ste 603
Seattle, WA 98122
t: 206.726.0034 | f: 206.726.9434

OFFICE ONLY: Date Sent: ___/___/___

Staff: _____

ATTN Physician: _____

Authorization to Release Confidential Health Information

I Hereby Authorize:

- Institute of Complementary Medicine* or
- Facility/Physician: _____
Address: _____
City: _____ State: _____ Zip: _____ - _____
Phone: _____ Fax: _____

To Release:

- Chart Notes: All or Specify: _____
- Labs/Reports: All or Specify: _____
- Billing Records: All or Specify: _____
- X-rays/Radiographic Images (specify): _____
- Other: _____

From the Health Records of:

Patient's Name: _____ Date of Birth: _____
 Daytime Phone: _____ Ext: _____ Evening Phone: _____
 Are you authorizing release of your own records? Yes No; relationship to the patient: _____

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 STDs, HIV and AIDS.

To be Released to:

- Institute of Complementary Medicine* or
1600 E Jefferson Street, Suite 603 | Seattle, WA 98122
phone: 206.726.0034 | fax: 206-726-9434
- Facility/Physician: _____
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 box(s) below to **EXCLUDE** the information)

- 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 for 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 contact the *Institute of Complementary Medicine* at 206.726.0034 to inquire about revoking authorization.

Print Patient's Name

Patient's Signature

Date

Print Name of Guardian or Responsible Party

Signature of Guardian/Responsible Party

Date