FEDERAL WAY NATUROPATHY

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

INFORMATION TO BE RELEASED BY:		INFORMATION TO BE RELEASED TO:	
FEDERAL WAY NATUROPATHY		Organization:	
900 SOUTH 336TH STREET		Address:	
FEDERAL WAY, WA 98003		City, State, Zip code	
Phone: (253) 942-3301	**Fax: (253) 237-0606**	Phone:	Fax:

PURPOSE OF DISCLOSURE

☐ Legal ☐ Continuing care outside FWN ☐ Insurance ☐ Other:_____

PERSONAL INFORMATION

NAME (Last, First, MI):

Month/Day/Year of Birth:	Previous Name:

MY AUTHORIZATION

You may use or disclose the following healthcare information (check all that apply)

☐ Healthcare information in my medical record relating to the following treatment or condition:

_____

☐ Healthcare information in my medical record for the following date(s): _____

☐ Other (e.g. X-rays, labs, bills) Specify date(s): _____

I understand that my records may contain information regarding the diagnosis and/or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released:

EXCLUDE The following information from the records released:

☐ HIV/AIDS ☐ Sexually transmitted infection ☐ Psychiatric disorders/mental health ☐ Drug/alcohol use

This authorization ends: (This document does not permit disclosure of health information created more than 90 days after the date it is signed)

☐ In 90 days from the date signed ☐ When the following occurs:_____

MY RIGHTS

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study, or
- To receive healthcare when the purpose is to create healthcare information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Federal Way Naturopathy based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. The way to revoke this authorization is to write a letter to Federal Way Naturopathy.

Once healthcare information is disclosed, the persons or organizations that receive it may re-disclose it. Privacy laws may no longer protect it.

Patient or leagally authorized individual signature	Date
Printed name if signed on behalf of patient	Relationship to patient