CENTER FOR HEALING NEUROLOGY

Authorization to Release Medical Records

PATIENT INFORMATION

Name (print)_____ DOB _____ SSN _____ - _____ - _____

INFORMATION TO BE RELEASED FROM

Name of facility or provider

Center for Healing Neurology

Address

2900 NE Blakeley St., Suite C, Seattle, WA 98105

INFORMATION TO BE SENT TO

Name of designated recipient

_____

Address _____ City _____ State _____ Zip _____

INFORMATION TO BE RELEASED (check one)

❒ The most recent 2 years of pertinent information (chart notes, labs, radiology, imaging, special tests, etc.)

❒ All medical records

❒ Specific information (please specify) : _____

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE (please check one)

❒ Attorney ❒Insurance ❒ Doctor ❒Personal

PATIENT AUTHORIZATION

I understand that my records may contain information regarding the diagnosis 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** (please initial)

_____Drug / Alcohol abuse/treatment & diagnosis _____ Sexually transmitted disease

_____HIV/AIDS diagnosis/treatment/testing _____ Mental illness or psychiatric diagnosis/treatment

MY RIGHTS

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____

(Patient or legally responsible party)

Signature: _____ Date: _____

(Minor Patient - Age 13-17*)

*Per Washington state law, minors must sign request themselves if information requested includes: a) treatment for alcohol or drug abuse (13 and older), b) mental health conditions or c) conditions related to the minor's reproductive care & sexual history to include contraception, pregnancy, pregnancy termination, sterilization, STDs (age 14 or older).

This authorization will expire 90 days from the date signed. Please fax request to 206-492-2003 or mail to Center for Healing Neurology, 2900 NE Blakeley St, Suite C, Seattle, WA 98105. If you have questions regarding your request please call: 206-379-1213 (allow 48 hours for your request to be received and entered into our system before calling).