



PATIENT INFORMATION

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

INFORMATION TO BE RELEASED FROM

Name of facility or provider _____

Address _____

INFORMATION TO BE SENT TO

Name of designated recipient _____

Center for Healing Neurology _____

Address	City	State	Zip
2900 NE Blakeley St., Suite C	Seattle	WA	98105

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. For records greater than 15 pages, please mail. Otherwise, fax this completed form 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).