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nwnaturopathicmedicine

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RELEASE OF INFORMATION

Patient Name _____ DOB _____

Address _____

Phone _____ Parent/Guardian _____

RELEASE TO (who you want to have access to your records):

NW Naturopathic Medicine

Self

Email records to _____

Hard copy mailed or available for pick up in office

Parent/Guardian/Other via Phone Patient Portal Email: _____

First Name _____ Last Name _____ Phone # _____

Outside Clinic:

Practice Name _____ Provider's Name _____

Address _____

Phone _____ Fax _____

RELEASE FROM (who has your records):

NW Naturopathic Medicine

Outside Clinic:

Name of facility _____ Provider's Name _____

Address _____

Phone _____ Fax _____

I authorize the above physician/clinic/hospital to release written records by checking the boxes pertaining to the following information. I have reviewed and understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. **THIS AUTHORIZATION EXPIRES 360 DAYS AFTER IT IS SIGNED.**

All Medical Records Labs and Diagnostic imaging Other: _____

Purpose of release: Transfer of care Coordination of care Referral/Consultation Personal Use

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Yes No

I authorize the release of any records regarding genetic testing to the person(s) listed above.

Patient/
Representative
Signature: _____

Date Signed: _____