Medical Records Release Form
Authorization for Emerald City Naturopathic Clinic, Inc., P.S. to Use or Disclose My Health Care Information

Patient name: _____ Date of birth:_____

Previous name: _____ SS#: _____

Address: _____ City: _____ State: ____ Zip Code: _____

I. <u>My Authorization</u>

You may use or disclose the following health care information (check all that apply):

All health care information in my medical record

Health care information in my medical record relating to the following treatment or condition: _____

Health care information in my medical record for the date(s):_____

Other (e.g., X rays, bills), specify date(s):_____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

HIV (AIDS virus) Sexually transmitted diseases

Psychiatric disorders/mental health Drug and/or alcohol use

Please disclose this health care information to:

Name (or title) and organization_____

Address: _____ City _____ State _____ Zip_____

Reason(s) for this authorization (check all that apply):

at my request

other (specify) _____
_____

check only if Emerald City Naturopathic Clinic requests the authorization for marketing purposes

check only if Emerald City Naturopathic Clinic will be paid or get something of value for providing health information for marketing purposes

This authorization ends: in 90 days from the date signed
on (date) _____
when the following event occurs _____
(no longer than 90 days from date signed)

II. <u>My Rights</u>

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

- To take part in a research study

or

- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Emerald City Naturopathic Clinic based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Emerald City Naturopathic Clinic.

or

- Write a letter to the Emerald City Naturopathic Clinic revoking the authorization

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)