

Authorization to Disclose My Health Care Information to Emerald City Naturopathic Clinic, Inc. P.S.

Patient name: _____ Date of birth: _____

Previous name: _____ SS#: _____

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

I. My Authorization: I hereby request and authorize:

Name of Physician or Clinic: _____

Physician Phone #: _____ **Physician Fax #:** _____

to 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 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:

Emerald City Naturopathic Clinic, Inc., P.S.
1409 NW 85th Street, Seattle, WA 98117 Phone: 206-781-2206 Fax: 206-783-3949

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

- at my request (check only if Emerald City Naturopathic Clinic requests the authorization for marketing purposes)
- other (specify) _____ (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:

- 90 days from the date signed
- on (date) _____
- when the following event occurs _____
(no longer than 90 days from date signed)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits. 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 my provider 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 my provider 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.)