nwnaturopathicmedicine

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RELEASE OF MEDICAL RECORDS REQUEST

Patient Name_____ DOB_____

Address _____

Phone_____ Parent/Guardian_____

RELEASE TO:

☐ NW Naturopathic Medicine
☐ Self
☐ Email records to_____
☐ Hard copy mailed or available for pick up in office
☐ Outside Clinic:
Name of facility _____Dr's Name_____
Address _____
Phone_____ Fax_____

RELEASE FROM:

☐ NW Naturopathic Medicine
☐ Outside Clinic:
Name of facility _____Dr'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

Definition: *Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.*

☐ 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: _____