Medical Records Release Form

Patient name: _____ Date of birth: _____

Previous name: _____ SS#: _____

Address:_____City/State/Zip:_____

Please circle where the records are coming "FROM" and where they are being released "TO"

To	From	To	From
Emerald City Naturopathic Clinic 1409 NW 85th Seattle, Washington 98117		Name of Physician or Facility: Address:	
P: 206 781 2206		P:	
F: 206 783 3949		F:	

You may use or disclose the following health care information:

- ☐ All health care information in my medical record
- ☐ Labs & imaging only
- ☐ Only these records:_____
- ☐ Only records dated from: _____ to _____

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

- ☐ at my request
- ☐ per doctor request
- ☐ coordination of care
- ☐ other (specify):_____

This authorization ends:

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

By initialing below, I understand that I am authorizing any and all records that may include information or testing regarding HIV, mental health, drug and alcohol abuse, or sexually transmitted diseases to be released to the above doctor or facility. _____

Signature:_____ Date:_____

(Parent or Guardian, if minor)

Relationship to Patient:_____