OLYMPIC NATUROPATHIC WELLNESS CENTER

17528 W. Main St., Monroe, WA 98272
Phone: 360-794-8183 Fax: 360-794-0305

Dr. Douglas K. White
Dr. Stephanie Taylor-White

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's
Name:_____D.O.B._____

SSN# _____-____-_____Maiden or Previous Name_____

Information to be released from: _____
Address: _____
Phone: _____ Fax: _____

Information to be sent to/or shared with:

Name of designated recipient: _____
Address: _____
Phone: _____Fax: _____

Information to be released (circle all that apply):

- The most recent 2 years of pertinent information. (Chart notes, labs, x-ray and special tests)
- All medical records
- Specific information (Please specify): _____

Purpose for which disclosure is being made: (Please circle one of the following)
Attorney Insurance Doctor Personal Verbal exchange of info

Patient Authorization:

I understand that my records may contain information regarding the diagnosis of treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

***EXCLUDE the following information from the records released (please initial):**

____Drug/Alcohol abuse treatment &diagnosis
____HIV/AIDS diagnosis/treatment/testing
____Sexually Transmitted Disease
____Mental Illness or Psychiatric diagnosis /treatment

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatments, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: _____**DATE:** _____
(Patient, Guardian, or Authorized Representative)
This authorization will expire 90 days from the date signed. Possible copying fee required.