

Natural Health Technologies

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name (s): _____

Previous Name: _____

BD: _____ Address: _____ Phone#: _____-_____-_____

Information to be released by:

Information to be released to:

Name (Dr./Facility) _____
Address _____
City, State, Zip _____
Phone#: _____ Fax#: _____

Name (Dr./Facility) _____
Address _____
City, State, Zip _____
Phone#: _____ Fax#: _____

Medical information to be released:

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, condition or date(s) of treatment _____
Other, specify date(s): _____

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

Drug/Alcohol abuse/treatment & diagnosis _____ Sexually Transmitted Disease
 HIV/AIDS diagnosis/treatment/testing _____ Mental Illness or Psychiatric diagnosis/treatment

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or 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 if the above area's are checked.

Purpose for which disclosure is being made: _____ Attorney _____ Insurance _____ Doctor _____
Personal

Washington Law:

RCW 70.02.010(15) allows medical providers to charge fees for searching and duplicating medical records. The fees a provider may charge cannot exceed the fees listed below:

- (1) Copying charge per page:
 - (a) No more than one dollar and two cents per page for the first thirty pages;
 - (b) No more than seventy-eight cents per page for all other pages.

(2) Additional charges:

(a) The provider can charge a twenty-three dollar clerical fee for searching and handling records;

(b) If the provider personally edits confidential information from the record, as required by statute, the provider can charge the usual fee for a basic office visit.

(3) This section is effective July 1, 2009, through June 30, 2011.

(4) HIPAA covered entities: See HIPAA regulation Section 164.524 (c)(4) to determine applicability of this rule.

My Rights: I understand I do not have to sign this authorization in order to obtain healthcare benefits (treatment, 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.

_____ Date _____

Signature of patient (if age 13 or older) or patient's authorized representative

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

This authorization expires (90) days from date of signature:(This document does not permit disclosure of health information created more than 90 days after the date it is signed).