



"Primary Care Naturally"

# Snohomish Naturopathic Clinic

1101 Avenue D, Suite D103, Snohomish, WA 98290

Phone: 360.568.2686 Fax: 360.862.8016

## Authorization To Release Medical Information

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Client # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_ SS #: \_\_\_\_\_

I authorize medical records to be released as follows:

<input type="checkbox"/> To Snohomish Naturopathic Clinic	<input type="checkbox"/> To
<input type="checkbox"/> From 1101 Ave "D"	<input type="checkbox"/> From
Suite D103	
Snohomish, WA 98290	Phone:
Fax: 360.862.8016	Fax:

For the purpose of review/examination, I further authorize you to provide such copies thereof as may be requested. The following is subject to such limitations as indicated below:

- Entire Record
- Specific Information: \_\_\_\_\_
- Old records from previous physician(s): \_\_\_\_\_

I give special permission to release any information regarding (Initial on applicable line(s) below):

- \_\_\_\_\_ Substance Abuse
- \_\_\_\_\_ Psychiatric/Mental Health Information
- \_\_\_\_\_ HIV Information

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE SIX MONTHS FROM THE DATE SIGNED. I UNDERSTAND THAT I MAY REMOVE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON.

Signed: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

### FOR OFFICE USE ONLY

Received: \_\_\_\_\_ Completed by: \_\_\_\_\_ Completed: \_\_\_\_\_

Amount billed: \_\_\_\_\_ Amount due: \_\_\_\_\_ Fee Paid: \_\_\_\_\_

Disclosure consisted of: \_\_\_\_\_