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RECORDS RELEASE FORM

PLEASE DO NOT FAX RECORDS MORE THAN 10 PAGES UNLESS MARKED URGENT

TODAY'S DATE: _____

PATIENT'S NAME: _____ DATE OF BIRTH:_____

REQUESTING FROM: _____ PHONE: _____

ADDRESS: _____ FAX: _____

RELEASE RECORDS TO: _____

I authorize the release of medical records. Please send the following information:

___ Chart Notes for the last 3 years
___ Lab for the last 3 years
___ Imaging Reports
___ Other: _____

I understand this consent allows you to release any healthcare information relating to testing, diagnosis and/or treatment of HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, drugs and/or alcohol use.

Reason for this authorization: ___ at my request ___transfer of care ___ other (specify): _____
This authorization ends: ___ 90 days from the date signed ___ on this date: _____

I understand I am signing this authorization and that I may revoke this authorization in writing. If I did, it would not affect any actions taken by Dr. Robin E. Moore, ND based upon this authorization. Two ways to revoke this authorization are: a) to fill out a revocation form (obtainable from Olympia Family Health, Inc); b) write a letter to Olympia Family Health, Inc. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized individual signature **Date**

_____ _____

Printed name if signed on behalf of the patient **Relationship**