Glow Natural Health Center
2719 E Madison St #203, Seattle, WA 98112
Ph: (206) 568-7545 * Fax: (206) 568-8298

Authorization to Release Confidential Health Information

I hereby authorize:

Facility/ Provider name: _____

Address: _____

City/State/Zip: _____

Fax: _____ Phone: _____

To release information from the health records of:

Name: _____

Date of birth: _____ ID/SSN: _____

Patient's daytime phone: _____

Dates of service: From _____ To: _____

Type of records: **All Records** **Chart Notes** **Imaging** **Lab Results** **Other:** _____

Information to be released to:

Glow Natural Health Center
2719 E Madison St #203
Seattle, WA 98112
Ph: (206) 568-7545 * Fax: (206) 568-8298

☐ Dr Candace McNaughton, ND
☐ Dr Eric Nissen, ND
☐ Dr Heather Bergfors, DC, DABCO
☐ Lindsey Lawson, MS, EAMP
☐ _____

Purpose of disclosure: Concurrent Care Transfer of Care Other: _____

This authorization is valid for ninety (90) days from the date signed. I understand that I can revoke this consent at any time, unless disclosure has already occurred in compliance with this consent.

Unless specifically excluded, this authorization includes release of specially protected information requiring specific written consent. This includes referral diagnosis and treatment related to substance abuse, mental health conditions and sexually transmitted diseases including HIV (CFP 42, part 2). Release of certain information also requires minor's consent. This applies to persons ages 13 to 18 for information pertaining to substance abuse and mental health information, or persons aged 14 to 18 for information pertaining to sexually transmitted diseases and HIV/AIDS.

I also understand that my information and records are protected under state and federal regulations regarding confidentiality and cannot be released or discussed without my written consent, unless otherwise provided for by law.

I understand that if I request records for personal use, to hand-carry to another health provider, or for parties not involved in patient care, there may be a charge. There may also be a charge for records mailed directly to another health provider.

Patient/Guardian: _____ Date: _____