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AUTHORIZATION TO RELEASE INFORMATION

(CIRCLE ONE) TO / FROM FUNCTIONAL MEDICINE NORTHWEST

Patient Name: ____________________________ Date of Birth: _____________

Address:___________________________________ Phone: __________________

I authorize information release to / from (circle one):

____
Physician/Third party

____
Address City State Zip

I authorize and request the disclosure of:

- ◊ Entire Medical Record
- ◊ History and Physical — Specific Date:___________________________________
- ◊ Medication and Therapy
- ◊ Lab, Pathology, EKG — Specific Type or Date:___________________________
- ◊ X-Ray Reports
- ◊ Films — Type ________ Date_________ Report_____________
- ◊ Other ____

Protected or sensitive information: I understand that certain information cannot be released without specific authorization as required by State/Federal law. BY INITIALING I authorize the release of the following protected or sensitive information.

_____ DRUG ABUSE DIAGNOSIS/TREATMENT _____ SEXUALLY TRANSMITTED DISEASES

_____ ALCOHOLISM DIAGNOSIS/TREATMENT _____AIDS/HIV TEST RESULTS

_____ MENTAL HEALTH/TREATMENT _____ GENETIC TESTING

By signing this form, you are authorizing the use of disclosure of your protected health information as described above. This information may be redisclosed if the recipient is not required by law to protect the privacy of the information.

You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire in 90 days from the date of signing.

You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization, With the exception of obtaining information in connection with eligibility or enrollment in a health plan.

______________________________________ _________________________ _____________
Signature of Patient or Legally Responsible Person Relationship to Patient Date