Yellow Pine Naturopathic Clinic

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Authorization to Release Protected Health Information

Name: _____ Date of Birth: _____

Other names used previously: _____

I authorize release of records as indicated below:

From:	To:
Practitioner: _____	Practitioner:_____
Facility:_____	Facility: _____
Address:_____	Address: _____
Phone: _____	Phone:_____
Fax: _____	Fax: _____

Information to be released; please indicate "all" or specific dates

- ☐ Complete chart record
- ☐ Chart notes: _____
- ☐ Labs: _____
- ☐ Imaging reports: _____
- ☐ Pathology reports: _____
- ☐ Immunization record: _____
- ☐ Other: _____

Unless specifically excluded, this authorization includes the release of specially protected information: referral, diagnosis, and treatment information related to substance abuse, mental health/psychotherapy, sexually transmitted infections (STIs), and HIV/AIDS.

Check the accompanying box(es) below to EXCLUDE the information from authorization:

☐ Substance abuse ☐ Mental health/psychotherapy ☐ STIs ☐ HIV/AIDS

I understand the conditions of this authorization:

1. Unless cancelled by me, this authorization is valid for 12 months from date of signing.
2. I may cancel this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.
3. If the person/organization receiving the health information is not a health care provider, the released information may no longer be protected by state and federal privacy regulations.
4. Not agreeing to or canceling this authorization may result in improper diagnosis or treatment, but it will not prevent me from receiving medical treatment.
5. I am entitled to a copy of this authorization form and will be provided with one at my request.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Office use only
Sent: _____
Date: _____