

**SWIFTWATER INTEGRATIVE MEDICINE**  
**413 N MAIN ST, SUITE H, ELLENSBURG, WA, 98926**  
**116 N OAKES AVE, SUITE C, CLE ELUM, WA, 98922**  
 Tel 509-240-8676  
 Fax 844-789-7048

**AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION**

**Please read all information and instructions before completing and signing the authorization form.**

Patient's Name \_\_\_\_\_ Birth date \_\_\_\_\_  
(Please Print) LAST FIRST MI  
 Are medical records filed under another name? \_\_\_\_\_ Phone Number \_\_\_\_\_

Information to be released to: <u>Swiftwater Integrative Medicine</u> Organization/Person Name <u>413 N Main St, Suite H, Ellensburg WA 98922</u> Street Address City, State, Zip <u>509-240-8676 844-789-7048</u> Phone Fax	Information to be released by: _____ Organization/Person Name _____ Street Address City, State, Zip _____ Phone Fax
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**TYPE OF MEDICAL INFORMATION REQUESTED:**

- Complete medical record abstract (includes 3 years of chart notes, most recent labs/pathology & diagnostic imaging reports)
- Cancer Partnership records  Radiology/ Diagnostic Imaging (CD/Films)  Mammogram Diagnostic Imaging (CD/Films)
- Echocardiograms  Pharmacy  Behavioral Health records only
- My health information relating only to the following treatment or condition: \_\_\_\_\_
- My health information only for the following date(s): \_\_\_\_\_
- Other: \_\_\_\_\_

REASON FOR REQUEST:  Personal  Transfer of Care  Disability  Insurance  Legal Review  Continuing Care  Other (please explain): \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby *specifically authorized to release* all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below.

**MINORS AGE 13-17:** A minor patient's signature is required in order to release the following information: (1) conditions relating to the minors reproductive care including, but not limited to: contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

**I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).**

**THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.**

This authorization expires \_\_\_\_\_ (date or event). Authorization will expire in 90 days if not otherwise specified.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient, if other than patient \_\_\_\_\_

(You may be required to provide legal documentation as proof for power of attorney or guardianship)

Federal and state laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains. A general release is NOT sufficient. 42 CFR Part 2: RCW 70.02.30