

**One Sky Wellness Associates**

6300 9<sup>th</sup> Ave NE, Suite 300, Seattle, WA 98115 Ph (206)363-5555 Fax (206) 363-5533

**AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION**

**I hereby authorize:**

- One Sky Wellness Associates
- Facility/Providers Name: \_\_\_\_\_
- Address: \_\_\_\_\_
- City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**To release:**

- Complete Chart (doesn't include billing information or other providers records unless specified below)
- Chart Notes:  All  Specify \_\_\_\_\_
- Labs and Reports:  All  Specify \_\_\_\_\_
- Billing Records:  All  Specify \_\_\_\_\_
- Imaging Reports:  All  Specify \_\_\_\_\_
- Other: \_\_\_\_\_

**From the health records of:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security number: \_\_\_\_\_ Phone #: \_\_\_\_\_

Are you authorizing release of your own records?  YES  NO

If not, what is your relationship to the patient? \_\_\_\_\_

(Release of certain medical information requires a minor's consent. This applies to information pertaining to substance abuse, mental health information, sexually transmitted diseases, HIV and AIDS. Others may apply.)

**To be released to:**

- Facility/Providers Name: \_\_\_\_\_
- Address: \_\_\_\_\_
- City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

- Myself (Provide current address below) – fee may apply

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

- One Sky Wellness Associates, Dr.** \_\_\_\_\_
- 6300 9<sup>th</sup> Ave NE, Suite #300, Seattle, WA 98115
- Phone (206) 363-5555 Fax (206) 363-5533

**For the purpose of:**

- Concurrent care  Transfer of care  Other (specify) \_\_\_\_\_

I understand that unless revoked this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document. Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to: (check below to EXCLUDE information from authorization related to:

- Substance abuse  Mental Health conditions/psychotherapy  Sexually transmitted diseases and  HIV / AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would be no longer protected. I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing. I may call (206)363-5555 to inquire about revoking authorization. I understand that if I request records for personal use, to hand carry to another healthcare provider or for parties not involved in my health care, there may be a charge. Non-emergency release of records may take up to 15 working days. Emergency requests will be given priority. Emergency status applies only to release of records directly to another healthcare provider for urgent patient care.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_