Authorization to Release Confidential Health Information

Dr. John Ruhland, The Natural Health Medical Clinic, LLC
206-723-4891 || mail@drruhland.com || 4002 - 25th Ave. S, Seattle, WA 98108

Office Only: Date Received: _____ Date Sent: _____ (rev. Jan 01, 2022)

I Hereby Authorize : (check only one)

□ Dr. Ruhland, The Natural Health Medical Clinic

□ *Facility / Doctor's Name: _____ (* required)

Street: _____ *City: _____ State: _____ Zip: _____

*Phone: _____ Fax: _____

To Release : (check all that apply)

□ Complete Chart Record

□ Chart Notes □ All or □ Specify: _____

□ Labs/Reports □ All or □ Specify: _____

□ Other: _____

From the Health Records of :

Name: _____ Date of Birth: _____ Soc. Sec.: _____

Street: _____ City: _____ State: _____

Daytime Phone(s): _____

Authorizing release of your own record? □ Yes. □ No, my relationship to the patient is as a _____

Release of certain medical information requires a minor's consent. This applies to persons aged 13-17 for information regarding substance abuse and mental health information, or persons aged 14-17 regarding sexually transmitted diseases, HIV/AIDS. Other laws may also apply.

To Be Released to : (check only one)

□ Dr. John Ruhland, The Natural Health Medical Clinic, LLC, 4002 - 25th Ave. S, Seattle, WA 98108

□ Self ($100 fee for this service)

Street: _____ City: _____ State: _____ Zip: _____

Daytime Phone(s): _____

Fax: _____ E-mail: _____

For the Purpose of :

□ Adjunctive / Concurrent Care □ Transfer of Care □ Other: _____

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. I wish to exclude referral, diagnosis and treatment information related to:

□ Substance abuse □ Mental health conditions/psychotherapy

□ Sexually transmitted diseases □ 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 for 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 no longer be 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 the Clinic at 206-723-4891 to inquire about revoking authorization.

I understand that if I request records for personal use, to hand-carry to another health provider, or for parties not involved in my health care, there may be a charge. 'Non-emergency' release of records may take up to 30 working days. Emergency requests will be given priority processing. 'Emergency' status applies only to release of records directly to another healthcare provider for urgent patient care. There is no charge to release records to another healthcare provider.

Patient's Signature: _____ Date: _____

Rep/Guardian's Signature: _____ Date: _____