North Peninsula Acupuncture PLLC
816 East 8th Street Port Angeles, WA 98362
(360) 457-0608

Authorization for the Release of Medical Records

This *authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. This clinic does not offer reimbursement for records received*.

Patient: _________________________________ DOB:_____/_____/_____

Please **obtain** information **from** the following:

____
Name of Clinic/Hospital

____
Street Address

____
City, State, Zip Code

Please **send** my medical information **to**:

____@
Name of Person to Receive Information

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Port Angeles, WA 98362

By ***checking*** the spaces below, I authorize the above physician/clinic/hospital to release written records pertaining to the following information ***going back one year***. I also authorize the above physician/clinic/hospital to provide the following information via telephone consultation:

____ Medical records needed for continuity of care

____ Diagnostic imaging reports

____ Laboratory reports

____ Pathology reports

____ I authorize open communication between above clinics concerning my care.

____ Other: ____

________________________ ____
Date Patient Signature

____
Signature of Parent/Guardian if Applicable