Leavenworth Integrative Medicine
10090 Main St Apt H
Peshastin, Washington, US - 98847-9770

LIM 2024 Health Record Release

Authorization for Release of Protected Health Records

Personal Details

First Name *

Last Name *

Date of Birth *

Gender ☐ Male ☐ Female ☐ Unknown

Blood Group

Language

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status ☐ Single ☐ Married ☐ Others

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker ☐ current status unknown ☐ Unknown if ever smoked

Primary Contact Details

Caregiver First Name

Caregiver Last Name

Email *

Home Phone

Mobile Phone

Work Phone

Fax

Primary Phone * ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 *

Address Line2

City *

Country *

State *

Zip code *

Postbox No

Emergency Contact Name

Emergency Contact Number

Extn

I hereby authorize the physician listed below to disclose my protected health information to Leavenworth Integrative Medicine, PLLC

Doctor or Facility Name: *

Phone and Fax:

Type of access requested (copies of the records): Check all that apply *

- ☐ Entire record
- ☐ Imaging/radiology
- ☐ Operative reports
- ☐ Laboratory reports
- ☐ Progress notes
- ☐ Medication records
- ☐ Nursing notes
- ☐ History and physical
- ☐ Rehabilitation services
- ☐ Cardiac studies
- ☐ Physician's orders
- ☐ ER records
- ☐ Consult reports
- ☐ Immunizations
- ☐ Demographics

I acknowledge, and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information. I understand that the term, Entire record, regarding release of protected Health Information means that only records generated by the named facility will be released. I have read the above and authorize the disclosure of the protected health information. I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that there may be a fee involved with the fulfillment of this request.

PATIENT SIGNATURE *