**MEDICAL RECORDS RELEASE FORM**

AUTHORIZATION for USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

 Last name First name MI Date of Birth

**I hereby authorize: To release information to:**

( ) Roots & Rivers Naturopathic Medical Center ( )

2208 2nd Street SE

East Wenatchee, WA 98802

P: (509)537-3660­­­­­­­­­­­­­­­­­­­­­­­­ P:

F: (833)390-1316

E: office@RootsandRivers.health

( ) ( ) Roots & Rivers Naturopathic Medical Center 2208 2nd Street SE

 East Wenatchee, WA 98802

P: P: (509)537-3660

 F: (833)390-1316

 Secure E: office@RootsandRivers.health

PURPOSE OF DISCLOSURE:

( ) Continuing care ( ) Worker’s compensation

( ) Payment of claim ( ) School

( ) Legal ( ) For personal use

( ) Other (specify):

INFORMATION TO BE RELEASED

Between the dates of:

( ) Progress notes/Provider notes

( ) Lab reports/Pathology

( ) X-Ray reports

( ) X-Ray films/MRI

( ) Other (specify content and dates):

ACKNOWLEDGEMENT OF UNDERSTANDING:

* I understand the expiration date of this authorization is one year from the date written below.
* understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
* understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.
* understand by authorizing this use or disclosure of information there will be no conditions placed on my health care or payment for my health care.
* I understand I will receive a copy of this form after I have signed it.

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Signature of patient, parent of minor, or personal representative Relationship Date