

**Authorization to Release Confidential Health Information**

**I hereby authorize:**

Facility/Doctor's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
FAX # \_\_\_\_\_

**To Release:**

Chart Notes: \_\_\_\_\_  
 Specify: \_\_\_\_\_  
\_\_\_\_\_

**From the Health Records of:**

Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Daytime Phone: \_\_\_\_\_

Are you authorizing the release of your own records? Yes \_\_\_ No \_\_\_

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

**To be released to:**

Rolando Fulgencio, ND  
Holistic Evaluations  
11201 SE Kent-Kangley Rd.  
Kent, WA. 98030  
206-303-0246

**For the Purpose of:**

Adjunctive/Concurrent 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 special protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to: (check the accompanying box(es) below to EXCLUDE the information from authorization)**

Substance abuse  
 Mental health/psychotherapy notes

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 healthcare 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 (206) 303-0246 to inquire about revoking this authorization.

**Patient's Name (print)** \_\_\_\_\_

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_