Mosaic Natural Health Clinic
13346 1st Ave NE, Seattle, WA 98125
Phone: (206) 361-2602 Fax: (206) 361-2605

Authorization to Release Confidential Health Information

I Hereby Authorize:

Mosaic Natural Health Clinic: □Dr. Andrews □ Dr. Nissen □Dr. Yarnell □Dr. Meyers
□Dr. Geiger □Dr. Sexton □Judi Epstein, ARNP □Dr. Carlson

Facility / Doctor's Name:____
Address:____
City:__________________________________ State: _______ Zip: ____________
Phone: __________________________ Fax: _________________________

To Release:

Complete Chart Record *(does not include billing information or radiographic images)*
Chart Notes ☐ All ☐ Specify: ____
Labs / Reports ☐ All ☐ Specify: ____
Billing Records ☐ All ☐ Specify: ____
X-rays / Radiographic images (Specifiy): ____
Other: ____

From the Health Records of:

Patient Name: _____________________________________ Date of Birth: ___________________
Soc. Sec. Number: _________________________ Daytime Phone: _________________ ext:____
Are you authorizing the release of your own records? ☐ Yes ☐ No
If not, what is your relationship to the patient? ____

To Be Released to:

Self (please provide current address) ** fee may apply**
Mosaic Natural Health Clinic: _____Other:_________________________
_____ Dr. Andrews _____ Dr. Nissen _____ Dr. Yarnell
Facility / Doctor's Name:____
Address:____
City:____________________________ State: _______ Zip: ____________________
Phone: _________________________ Fax: _________________________________

For the Purpose of:

Adjunctive / Concurrent Care
Continuation of Care
Transfer of Care
Legal
Insurance
Patient Request
Other___________________

Special Authorization:

I authorize the release of the information below (please initial each category that you wish to release)
_______HIV / AIDS _________Sexually Transmitted Diseases
_______Mental Health Care _________Substance Abuse

I understand that in order to revoke this authorization, I must do so in writing. I understand that my health care information is protected by state and federal regulations. I understand 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 to receive care, and that I am entitled to a copy of this form at the time of signing. I may call the clinic to inquire about revoking authorization. I understand that if I request records for personal use, to hand carry to another provider, or for parties not involved in my health care, there may be a charge. There is no charge to release records to another healthcare provider. This authorization expires in ______ days (90 days if not otherwise specified). Minors signature required for certain conditions.

_____________________________________ _______________ ______________________________

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Patient Signature	Date	Relationship to Patient