Authorization to Disclose Protected Health Information To
Wenatchee Holistic Medicine

Patient Name:_____

Phone: _____-_____ Date of Birth: ____/_____/_____

As required by the Privacy Regulations, WHM may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize: _____

Address: _____
Street number ***City*** ***State*** ***Zip***

FAX:_____

to disclose my Patient Health Information to
Wenatchee Holistic Medicine Ph- 509-387-0336

mail or fax to:
Dr Rian Herscher
411 N Mission St
Wenatchee, WA 98801
Fax: 509-293-9343

By ***initialing*** *the spaces below, I authorize the release of the following records, if such records exist:*

____Laboratory report (preferred) ____ Entire medical record ____ Progress notes

____ Imaging ____ Operative report

___ Other, Please be specific:_____

- The following items must be **initialed** to be included in other documents:

___ HIV/AIDS related record ___Mental Health records
___ Drug/Alcohol diagnosis, treatment or referral information ___Genetic testing information

(Federal regulations require a description of how much information and what kind of information is to be disclosed). Describe_____

For the specific purpose of (describe in detail):

_____

This authorization will expire 180 days from the date of signing.
I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.
7. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____/_____/_____
Signature of Patient or Patient's Authorized Representative (relationship) *Date*