

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Advanced Holistic Health, PLLC  
Queen Anne Clinic, Seattle | Eastgate Clinic of I-90, Bellevue  
Fax: 206-826-6399

(Name) \_\_\_\_\_ (DOB) \_\_\_\_\_

(Address) \_\_\_\_\_ (Phone) \_\_\_\_\_

I authorize: \_\_\_\_\_  
(Provider or Institution, City) \_\_\_\_\_  
(Phone / Fax) \_\_\_\_\_

To release:

- Clinic and treatment notes for the past \_\_\_\_\_ years
- ED notes, operative reports, & hospital summaries for the past \_\_\_\_\_ years
- Consultation reports for the past \_\_\_\_\_ years
- Image and radiology reports for the past \_\_\_\_\_ years
- Lab reports for the past \_\_\_\_\_ years
- Pathology reports for the past \_\_\_\_\_ years
- Other \_\_\_\_\_

Please check to authorize release for any of the following:

- I do  I do NOT Information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV Infection
- I do  I do NOT Psychiatric care and/or psychological assessment
- I do  I do NOT Treatment for alcohol and/or drug abuse

RELEASE TO (by Mail or Fax):

**Advanced Holistic Health, PLLC**  
14648 SE Eastgate Way #A  
Bellevue, WA 98007

**Advanced Holistic Health, PLLC**  
508 3<sup>rd</sup> Ave W, Suite B  
Seattle, WA 98119

Questions? 24/7 Phone Service: 888-508-5724 Local Clinic Line: 425-243-2441 **eFax To: 206-826-6399**

I hereby authorize disclosure of the health information for the above named patient to Advanced Holistic Health. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of Patient or Legal Representative of patient \_\_\_\_\_ Date \_\_\_\_\_

If signed by legal representative, describe authority to act on person's behalf: \_\_\_\_\_