Water's Edge
NATURAL MEDICINE

RECORDS RELEASE AUTHORIZATION

I hereby authorize: **WATER'S EDGE NATURAL MEDICINE**

3131 ELLIOTT AVE, SUITE 740

SEATTLE, WA 98121

Tel: 206-283-1383 Fax: 206-283-1924

To release the following confidential medical information from the health record of:

Name: _____

Date of Birth: _____

_____Copy of complete health record From: _____ To:_____

_____Lab results (specify)

_____X-Ray reports/film (specify)

_____Other (specify)

Information is to be released to (self or other) :

Paper copies of medical records may be released upon receipt of written authorization of patients over the age of 18 or a legal guardian. Once authorization is received, it may take *up to 10 business days* to process your request.

There is a charge to obtain copies of medical records. If requested for private use by patients or guardians:

- No charge to the patient when records are sent via fax.
- No charges for page count if 10 pages or less.
- $0.20 per page for 10 pages and over plus shipping/handling.

If the records are needed for continuing care, there is no charge to the patient when records are sent (via fax) directly to your *physician* or the *facility providing treatment*. If records are needed for treatment or for an appointment within the next 48-72 hours, physicians can request records by fax when you arrive in his/her office for treatment.

This authorization is valid for 365 days from the date signed. I understand this consent can be revoked at any time to the extent that disclosure made in good faith has already occurred in reliance on this consent.

I also understand that my records are protected under the federal and state confidentially regulations and cannot be disclosed without my written consent otherwise provided for in the regulations.

Patient/Guardians Signature _____ **Date** _____

NOTE: Records containing information in relation to drug, alcohol, mental health and sexually transmitted diseases testing, diagnosis and treatment require a SPECIAL AUTHORIZATION.