Records Request & Authorization To Release Health Information

PLEASE Mail to: 509 Olive Way # 1658, Seattle, WA 98101

Patient's name: _____ Date of Birth: _____

I request and authorize _____
(Physician/Provider)

of _____
(Physician/Provider Address)

_____
(Physician/Provider Phone Number)

to release health care information of the patient named above to: Desiree Merulli, L.Ac., EAMP, LMP of Merulli Acupuncture.

I also authorize Desiree Merulli L.Ac., EAMP, LMP, to release my health care records to the above listed physician/provider.

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____ All health care information

_____ X-rays

_____ Other

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

_____
Signature of Patient or Patient's Authorized Representative Date

_____
Relationship or status if signed by anyone other than patient

This authorization expires 90 days after the date it is signed.