Dr. Sierra Breitbeil ND
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105 Norfolk Rd, Mail: 31 Hi Way, Winthrop, WA 98862 509-996-3970 Fax: 888-672-2468

Authorization for Disclosure of Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

1. *I authorize the use or disclosure of the above named individual's health information as described below.*

2. *The following individual or organization is authorized to make the disclosure:*

   Name: _____

   Address: _____

3. *The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).*

   _____ Complete health records, including all prog. notes and objective labs/radiology

   _____ Complete health records between the dates: _____ to _____

   _____ Lab results blood only between the dates: _____ to _____

   _____ X-ray, CT, U/S or MRI approximate date/(s) _____

   _____ Physical exam and accompanying lab results from approximate date_____

   _____ Consultation reports from specialist approximate date referred _____

   _____ Immunization record

4. *I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. Initials* _____

5. *Please send information as: CD by mail* _____ *Paper copies by mail* _____ *Fax*_____ *Email*_____

6. *This information may be disclosed to and used by the following individual or organization: (Please select below)*

   _____ Methow Valley Wellness Center, Dr. Sierra Breitbeil ND, Naturopathic Doctor

   31 Hi Way, Winthrop WA 98862 **Fax:** 888-672-2468 **Email:** SierraBreitbeil@gmail.com

   _____ Other

   Name: _____ Fax: _____

   Address: _____ Email: _____

7. *I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: Initials* _____

8. *If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:*

_____ _____

Signature of patient or legal representative Signature of witness

Date: _____ Date: _____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.