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AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Name ________________________________ **Date of Birth** _________________

Phone _______________________________

I am requesting my records be sent **to** Evergreen Natural Health Center **from**:
Name/Address:
____

____

Phone ______________________________

OR

Please send my records **from** Evergreen Natural health center **to**:
Name/Address:
____

____

Fax ____________________ Initial to give permission for records to be faxed. ______

All faxed material does include a confidentiality statement, however this does not guarantee confidentiality on the receiving end.

Records I am requesting:
- ☐ Chart notes
- ☐ Imaging reports
- ☐ Labs
- ☐ Complete Medical Chart*
- ☐ Other__________________________

For the purpose of:
- ☐ Self
- ☐ Continuation of care

Date Range ☐ All ☐ From __________________ to __________________

I have reviewed and understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

The following items must be initialed to be included in the use/disclosure of your health information:
_____ HIV/STI/AIDS _____Drug/alcohol diagnosis, treatment, or referral info
_____Mental health _____Genetic testing information

Signature: ____ Date: _______________