Records Release Authorization

425.999.4503 (Office) | 425.646.4770 (Fax) 15613 Bel-Red Rd, Suite B,
Bellevue, WA 98008
Trina Seligman, N.D., L.Ac

Patient Name: ________________________________ DOB: ____/____/____

I authorize the following release of information as stated below from the patient health information record.

Information to be release from:	Information to be release to:
______________________________ Organization / Physician	______________________________ Organization / Physician
______________________________ Street Address	______________________________ Street Address
______________________________ Phone Fax	______________________________ Phone Fax

Information to be released:

Dates of service for records requested: Beginning: ____/____/____ Thru: ____/____/____

☐ Chart Notes ☐ Lab / Pathology Reports ☐ Radiology Reports

☐ Operative Reports ☐ Other (specify): ________________________________

Purpose of release:

☐ Continuing Care ☐ Personal Copies ☐ Transfer to another provider

☐ Legal ☐ Other (specify): ________________________________

Sensitive records may require specific patient authorization. Please check the applicable box below to request the following records:

☐ Mental Health ☐ AIDS / HIV Treatment

☐ Sexually Transmitted Infections ☐ Substance Abuse Treatment

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by writing to Evergreen Integrative Medicine. I understand that once the information has been released, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire 90 days from the date signed below unless another date is entered: _____/_____/_____

______________________________ ______________________________
Patient Signature Patient's Guardian Signature (IF MINOR)

____
Date