Harmonizing Natural Medicine: a Naturopathic Clinic
3417 Evanston Ave N Suite 429, Seattle, WA 98103
Ph) 425-270-7187 Fax) 425-249-7448 Email) Info@hnhclinic.com

Authorization to Disclose (Release) Health Care Information

1. Individual information:

Patient Name (Previous Name)	
Date of Birth	
Address, City, State, ZIP	

2. Information may be disclosed by/to

Please circle where the records are coming "FROM" and where they are being released "TO"

FROM /TO	Name of provider, or organization releasing information	**TO** / FROM
		Harmonizing Natural Medicine Dr.MJ(MINJUNG) KANG
	Address, City, State, Zip	**3417 Evanston Ave N #429 Seattle, WA 98103**
	Office Phone	**425 270 7187**
	Office Fax	**425 249 7448**

3. What kind of information do you want disclosed? (Check all that apply)

- ☐ All records from the last 2 years of visits
- ☐ Information date FROM _____ /_____ /_____ TO_____ /_____ /_____
- ☐ Labs & imaging only
- ☐ Specific Information (specify): _____
- ☐ Other: _____

4. Reason(s) for this authorization (check all that apply):

☐ at my request ☐ per doctor request ☐ coordination of care ☐other (specify):_____

5. This authorization ends:

☐ in 90 days from the date signed ☐ on (date):_____(no longer than 90 days from date signed)
☐ when the following occurs:_____(no longer than 90 days from date signed)

Authorization

Information released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness. I give my specific authorization for this information to be released. _____initial.

Rights

Generally, Harmonizing Natural Health, PLLC and any other entity covered by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I may revoke this authorization in writing. Once the information I have authorized to be disclosed is disclosed, it may no longer be protected under health information privacy laws. If I revoke my authorization, it will not affect any actions already taken by Harmonizing Natural Health, PLLC based upon this authorization.

_____

Paient or legally authorized individual **Signature and Date**

_____

Printed Name and **Relationship** (parent, legal guardian, personal representative, etc.)