Snohomish Naturopathic Clinic
1101 Avenue D, Suite D103, Snohomish, WA 98290
Achieve Optimal Health Phone: 360.568.2686 Fax: 360.862.8016

Authorization To Release Medical Information

Patient: _____ DOB: _____ Client #_____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Alt. Phone: _____ SS #: _____

I authorize medical records to be released as follows:

❒ To ❒ From	Snohomish Naturopathic Clinic 1101 Ave "D" Suite D103 Snohomish, WA 98290 Fax: 360.862.8016	❒ To ❒ From	 Phone: Fax:

For the purpose of review/examination, I further authorize you to provide such copies thereof as may be requested. The following is subject to such limitations as indicated below:

- ❑ Entire Record
- ❑ Specific Information: _____
- ❑ Old records from previous physician(s):_____

I give special permission to release any information regarding (Initial on applicable line(s) below):

_____ Substance Abuse
_____ Psychiatric/Mental Health Information
_____ STI, HIV and AIDS Information

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE SIX MONTHS FROM THE DATE SIGNED. I UNDERSTAND THAT I MAY REMOVE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON.

Signed: _____ Relationship: _____ Date: _____

Witnessed: _____ Title: _____ Date: _____

FOR OFFICE USE ONLY

Received: _____ Completed by: _____Completed :_____

Amount billed: _____ Amount due: _____ Fee Paid: _____

Disclosure consisted of: _____