Institute of Complementary Medicine
1600 E Jefferson Street, Suite 603
Seattle, WA 98122-5649

Authorization to release information - ICM

Authorization to Release Confidential Health Information

I Hereby Authorize: ☐ Institute of Complementary Medicine or ☐ Facility/Physician(provide details below

Facility/Physician name _____

Address: _____

_____

_____

_____

City _____

State: _____

Zip _____

Phone _____

Fax _____

_____

_____

_____

To Release:

Chart Notes : ☐ All ☐ Specific

If specific, list them : _____

_____

_____

_____

Labs/Reports : ☐ All ☐ Specific

If specific, list them : _____

_____

_____

_____

Billing Records : ☐ All ☐ Specific

If specific, list them : _____

_____

X-rays/Radiographic Images (specify) _____

Any others, specify : _____

From the Health Records of:

Patient's Name _____

Date of Birth _____

Daytime Phone(along with Ext., if any) _____

Evening Phone _____

Are you authorizing release of your own records? * ☐ Yes ☐ No

Relationship to the patient _____

Release of certain medical information requires a minor's consent. This applies to persons aged 13 to 17 for information pertaining to substance abuse and mental health information, or persons aged 14 to 17 for information pertaining to STDs, HIV and AIDS

To be Released to : ☐ Institute of Complementary Medicine, 1600 E Jefferson Street, Suite 603 | Seattle, WA 98122 phone: 206.726.0034 | fax: 206-726-9434 ☐ Facility/Physician(specify details below)

Facility/Physician name _____

Address(along with City, State, Zip, Phone and Fax) _____

For the Purpose of : ☐ Concurrent Care ☐ Transfer of Care ☐ Others _____

I understand that unless revoked this authorization is valid for 90 days from the date of

signing. I understand that I may revoke this
authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.

Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization
for release.

This includes referral, diagnosis and treatment information related to: (Check box(s) to EXCLUDE the information)

- ☐ Substance abuse
- ☐ Mental health conditions/Psychotherapy
- ☐ Sexually transmitted diseases
- ☐ HIV/AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this
information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise
provided for by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive
my health care information, my information may be re-disclosed by that party and would no longer be protected. I understand that I
do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the
time of signing. I may contact the Institute of Complementary Medicine at 206.726.0034 to inquire about revoking authorization.

Patient/Guardian/Responsible Party Name * _____

Relationship _____

Patient/Guardian/Responsible Party Signature : _____