

LE VISAGE
WELLNESS CENTER AND DAY SPA
4430 106TH STREET SW #103, MUKILTEO, WA 98275 (425) 493-6868

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

I Hereby Authorize:

Facility Name _____
Address _____
City/State/Zip _____

To Release Information From the Health Records of:

Name _____
Date of Birth ____/____/____ ID Soc. Sec. Number _____
Dates of Service: From _____ to _____ Day Phone _____

Information to be Released:

_____ Copy of Complete Health Records
_____ Lab/Test Results (specify) _____
_____ X-ray Reports and/or Films (specify) _____
_____ Billing information for Dates of Service _____
_____ Other (specify) _____

Information to be Released to:

Dr. Said Sokhandan, ND, LAC, MS
Le Visage Wellness Center
4430 106th Street SW #103 (425) 493-6868
Mukilteo, WA 98275

Purpose of Disclosure: _____

This Authorization is valid for ninety (90) days from the date signed. I understand that I can revoke this Consent at any time, unless disclosure has already occurred in compliance with this consent.

Unless specifically excluded, this authorization includes release of specially protected information requiring specific written consent. This includes referral diagnosis and treatment related to substance abuse, mental health conditions, and sexually transmitted diseases including HIV/AIDS (CRF 42, Part 2). Release of certain information also requires a minor's consent. This applies to persons Aged 13 to 18 for information pertaining to substance abuse and mental health information for persons Aged 14 to 18 for information pertaining to sexually transmitted diseases and HIV/AIDS.

I also Understand that my information and records are protected under state and federal regulations regarding confidentiality and can not be released or discussed without my written consent, unless otherwise provided for by law.

I understand that if I request records for Personal use, to hand carry to another Health provider, or for parties not involved in patient care, there may be a charge. There is no charge for records mailed directly to another health care provider.

Patient/ Guardian Signature _____ Witness _____
Date _____ Witness Relationship to Patient _____
Minor Consent (if required) _____