12911 120th Ave NE Suite E-50
Kirkland, WA 98034
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stellina
NATURAL MEDICINE

18 & Over - HIPAA Release and Consent Form

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or appointment status without my specific written permission. Stellina Natural Medicine will not speak with my parents, permit my parents to schedule appointments, or release medical information to my parents without my written consent in accordance with this document.

This Authorization will be valid through 21 years of age_____, or one year from TODAY'S DATE:_____, or on the following DATE:_____.

_____ I DO NOT grant any access to my parents and/or guardians. No medical information, records or appointment information can be discussed or released.

For the purpose of helping me with my healthcare,

_____ I WISH TO grant my parents and/or guardian access to my healthcare providers and/or medical information as follows: I give the below-named individual(s) permission to act on my behalf.

I understand that they may contact any physician or member of the staff at Stellina Natural Medicine to schedule appointments, discuss my healthcare, and access my medical records. Please specify if you wish to include the following (Initial Yes or No):

Yes, include	No, do not include:	
_____	_____	Sexually Transmitted Disease/ Communicable Diseases
_____	_____	Pregnancy/Sexual Activity
_____	_____	Mental Health
_____	_____	Substance Abuse

_____
(Print Name of the parent or guardian; indicate their relationship to you.)

_____
(Print Name of second parent or guardian; indicate their relationship to you.)

I understand that:

1. The purpose is provided above so that I can make a decision as to whether to allow the release of information.
2. The disclosing office will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI, except for minimum fees for copying and postage.
3. I do not have to sign this authorization in order to receive treatment.
4. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule or other law protecting its confidentiality.
5. I have the right to revoke this authorization in writing, except where the office has acted in reliance upon it. My written revocation must be submitted to: Stellina Natural Medicine - 12911 120th Ave NE Suite E-50 - Kirkland, WA 98034, OR to the Privacy Officer of the facility that is releasing information.
6. This form may be deemed INVALID if all sections are not completed.

_____ _____ _____

PATIENT SIGNATURE PATIENT PRINTED NAME DATE OF BIRTH

PATIENT CELL PHONE: _____TODAY'S DATE _____