Stellina Natural Medicine
12911 120th Ave NE, Ste E50, Kirkland, WA 98034
Phone: 425.820.7700 • Fax: 425.820.7707

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ DOB:_____

I request and authorize _____ Fax:_____

Address:_____ Tel:_____

to release health care information of the patient named above to:

____ Dr. Candace Aasan ____ Dr. Anna Evershed ____ Dr. Vivian Sovran ____ Dr. Andrea Lutac 12911 - 120th Ave NE, Suite E-50 Kirkland, WA 98034	____ Other Name: Address: Tel: Fax:

Information to be released:

☐ Vaccination records and growth charts
☐ All health care information
☐ Other:

Purpose for disclosure:

____ Attorney ____ Insurance ____ Doctor ____ Personal ____ School

Patient Authorization:

I understand that my specific consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorder/mental health conditions, or drug and/or alcohol use. I am specifically authorizing the release of all health care information relating to such diagnosis, testing, or treatment.

EXCLUDE the following information from the records released (please initial):

____ Substance abuse
____ HIV/AIDS diagnosis/treatment/testing
____ Sexually transmitted diseases
____ Mental health conditions/treatment

Patient rights:

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. 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. **I understand that if I request records for personal use, to hand-carry to another healthcare provider, or for parties not involved in my healthcare, there will be a $25 charge. All records requests will be processed within 5 business days.**

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Relationship to patient: _____