The Evergreen Clinic

Integrative Psychiatric and Wellness Medicine
12025 115th Ave NE, Suite 200, Kirkland, WA 98034
Ph: (425)821-1810 Fax: (425)823-1231 New Patient Intake: (425)825-9644

RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Previous or Alternate Name: _____

I authorize the use or disclosure of the following health care information (check all that apply):

- ○ All healthcare information in my medical record
- ○ Healthcare information in my medical record relating to the following treatment or condition: _____
- ○ Healthcare information in my medical record for the date(s): _____
- ○ Other: _____

Release Records from:	Released to:
_____	_____
_____	_____
_____	_____

Reason for this request:

○ Per my request ○ School Requirement ○ Transfer of care ○ Other: _____

I acknowledge that this authorization expires in one year, unless noted here: _____

I understand the following rights:

1. My records and healthcare information is protected under State and Federal regulations.
2. I do not have to sign this authorization in order to receive healthcare benefits (treatment, payment, or enrollment).
3. I may revoke this authorization in writing. If revoked, this would not affect any actions already taken by The Evergreen Clinic based on this authorization. I may not be able to revoke this authorization if its' purpose was to obtain insurance.
4. Once healthcare information is disclosed, the person or organization that receives it may not re-disclose this information without my written consent.

Patient or Legal Custodian Signature: _____
Date: _____

Printed name if signed on behalf of the Patient: _____