Authorization to Release Health Information

Patient Name _____ Date of Birth _____

I authorize: Organization/Person Name _____
Street Address _____
City, State, Zip _____
Telephone/Fax Number_____

To release my protected health information to (or obtain protected health information from):

Nourish Wellness, PLLC
Yamileth Cazorla-Lancaster, DO, MPH, MS
3105 Summitview Ave., ste. 3
Yakima, WA 98902
Office: 509-969-6214
Fax: **1-888-565-2493**

Records Requested: Health care information related to the following treatment or condition:
_____

Date range for the information requested:
- ☐ Last year
- ☐ Last two years
- ☐ Specified date range _____

☐ I understand that if my record contains information concerning alcohol or drug abuse/treatment, mental health (including pain management or psychiatry records) or sexually transmitted diseases (including HIV/AIDS), such information will be ***included*** in this disclosure. ***Sensitive records require specific patient authorization if the patient is an adolescent, therefore, we request patients age 13 years or older to also authorize release of information.***

☐ I want to ***exclude*** the following:
- ☐ Alcohol or drug abuse treatment
- ☐ Mental Health
- ☐ Sexually transmitted diseases
- ☐ HIV/AIDS

The purpose for this information is for continuity of care with the above named person(s)/organization.

Patient rights: I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when the recipient has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I acknowledge that I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize the release of patient health information to the above named person or organization. Release will expire in 90 days from the date signed.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Relationship to Patient Telephone number

_____
Patient Signature (if age 13 or older)