Metamorphe Health Clinic
3976 E. Harbor Road
Langley, WA 98260
360-221-2050

Mailing address:
P. O. Box 1072
Freeland, WA 98249

RECORDS RELEASE AUTHORITY

The material requested by this release may contain information that is confidential and protected by law. It is intended only for the use of the individual or entities named above. Any further disclosure of information is strictly prohibited. If you have received this communication in error, please contact the sender.

TO: _____ (Name of Doctor)
LOCATION OF OFFICE: _____ PHONE: _____FAX: _____

I, _____(Print Patient's Name) hereby request that you release to:

DR. SUSAN E. AZAR copies of all test results as well as any other data pertinent to your treatment of me from _____to _____Please mail to the above address or Fax to the above number.

(Signature of Patient or Guardian)_____

(Date of Request) _____

(Date of Birth) _____

(Witness) _____ _____

(Date) _____ _____

(Address) _____

I understand that I do not have to sign this authorization in order to get health care benefit (treatment, payment, enrollment or eligibility for benefits) except if I receive healthcare when the sole purpose of the healthcare is to create health information for a third party.

I understand that 1) I must revoke my authorization in writing and may do so by completing and signing the Revocation of Authorization form available at my clinic; b) if I revoke my authorization, it will not affect any actions already taken by Metamorphe Health Clinic based upon this authorization; and c) I may not be able to revoke this authorization if the purpose of it was to obtain insurance.

Once Metamorphe Health Clinic has disclosed health information, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information.

I understand that this authorization does not permit the release of information related to health care provided to me more than ninety days after the date of this authorization. This prohibition does not extend to insurance companies.

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____All records in my chart (including labs, reports, chart notes, referrals etc.)

____Just my lab records

____Only chart notes/labs related to: _____

TO: _____ (Name of Doctor)

LOCATION OF OFFICE: _____

PHONE: _____FAX: _____

Please mail to the above address or Fax to the above number.

(Signature of Patient or Guardian)_____

(Date of Request) _____

(Date of Birth) _____

(Witness) _____ _____

(Date) _____ _____

(Address) _____

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