Riverbend Integrative Medicine

&

Natural Healing Family Medicine

Authorization to Release Confidential Health Information

I hereby authorize:

- Dr. Lori Wieser, N.D.
- Facility/Doctor's Name:____

  Address:____

  City:______________________State:__________________Zip Code:_____________

  Phone:______________________________Fax:_____________________________

To release:

______Complete Chart Record (does not include billing information or radiographic images)

______Chart notes

_____All _____Specify:____

______Lab Report

_____All _____Specify:____

______Billing Records

_____All _____Specify:____

______X-rays and radiographic images

_____All______Specify:____

From the Health Records of:

Name:____Date of Birth:__________________

SS#:____________________Daytime phone:_____________________________Ext:__________

Are you authorizing the release of your own records? Yes______No______

If not, what is your relationship to the patient?____

Release of certain information requires minor consent. This applies to persons aged 13-17 for information pertaining substance abuse and mental health information, or persons aged 14-17 for information pertaining to sexually transmitted diseases, HIV, and AIDS. Other laws may apply.

To be released to:

- Dr. Lori Wieser, N.D.
- Facility/ Doctor's Name:____

  Address:____

  City:______________________________________State:____________Zip code:______

  Phone:____________________________Fax:_____________________________________

For the purpose of:

_____Adjunctive Care _____ transfer of care______other:_______________________

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.

Unless specifically excluded, this authorization includes the release of specifically protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to: (check the accompanying box(es) below to EXCLUDE the information from authorization)

____Substance Abuse _______Mental Health conditions/Psychotherapy _____Sexually Transmitted Diseases

____HIV/ AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided by law. I also may be re-disclosed by that party and would no longer be protected.

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 at the time of signing. I may call Dr. Lori Wieser's office at 360-584-9182 before May 7th 2016 and after May 7th 406-407-9245 to inquire about revoking the authorization.

I understand that if I request records for personal use, to hand-carry to another provider, or for parties not involved in my healthcare, there may be a charge. "Non- Emergency" release of records may take up to 30 working days. Emergency requests will be given priority processing. "Emergency" status applies only to release of records directly to another healthcare provider for urgent patient care. There is no charge to release of records to another healthcare provider.

Patient's Signature:____Date:_________________________

Guardians Signature:____Date:_________________________

Guardian's Relationship to the patient:_________________________________

Mail or Fax to:

Lori Wieser N.D.
P.O. Box 133
Elma, WA 98541
Ph: 360-402-4943
Fax: 360-482-3527