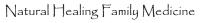


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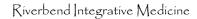




Authorization to Release Confidential Health Information

I hereby author	ize:					
o I	Dr. Lori Wieser, N.D).				
	·	ıme <u>:</u>				_
					ip Code <u>:</u>	_
1	Phone:		F	эх:		_
To release:						
Cc	omplete Chart Reco	ord (does not include b	illing in	formation or ra	diographic images)	
C	nart notes					
-	AllSp	ecify:				
La	ıb Report					
-	AllSp	ecify:				_
Bi	lling Records					
-	AllSpe	ecify:				_
X-	rays and radiograp	hic images				
<u>-</u>	AllSpe	ecify:				-
From the Health	h Records of:					
Name:				Date of Birth	:	
SS#:		_Daytime phone:			Ext:	
Are you a	uthorizing the relea	ase of your own recor	ds? Yes	No	_	
If not, wh	at is your relations	hip to the patient?				
ertaining substar	nce abuse and men		or pers	ons aged 14-17	ed 13-17 for information for information pertain	
To be released	to:					
o I	Dr. Lori Wieser, N.D).				
	•	ame:				
						_
				State:	Zip code:	_
						_
For the purpose			- ·			_
	Adjunctive Ca	are transfer of	care	other:		





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Natural Healing Family Medicine



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.

accordance with this docar	iiciic.	
•	d, this authorization includes the release of speci	• •
	orization for release. This includes referral, diagno	
•	empanying box(es) below to EXCLUDE the information	
	Mental Health conditions/Psychotherapy	Sexually Transmitted Diseases
HIV/ AIDS		
understand that my healt	hcare information is protected by state and federa	al regulations that protect the
confidentiality of this infor	mation and that my healthcare information may n	ot be released or disclosed without
my written authorization, (unless otherwise provided by law. I also may be re	e-disclosed by that party and would no
onger be protected.		
understand that I do not	have to sign this form as a condition for receiving t	reatment and that I am entitled to a
copy of this authorization f	form at the time of signing. I may call Dr. Lori Wies	er's office at 360-584-9182 before
May 7 th 2016 and after Ma	y 7 th 406-407-9245 to inquire about revoking the	authorization.
understand that if I requ	est records for personal use, to hand-carry to ano	ther provider, or for parties not
	there may be a charge. "Non- Emergency" releas	
working days. Emergency	requests will be given priority processing. "Emerg	gency" status applies only to release
	her healthcare provider for urgent patient care. 1	
ecords to another health	care provider.	
Patient's 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