Naturopathic Dermatology
Christa Lamothe, ND
P.O. Box 102
Edmonds, WA 98020
Telephone: 425-361-1795
Facsimile: 425-361-1821

Authorization for Disclosure of Medical Records or Health Information

Specified medical or health information will be released for the patient as indicated below upon appropriate completion of this authorization.

Patient name (Last, First, MI):
_____
Date of birth: _____
Address:_____
Telephone number: _____

Information to be released **(please check one) ___to __by:**
(i.e. Physician's complete name/Healthcare facility/ Self):
_____
_____
Telephone number: _____
Fax number: _____
Address: _____
_____
_____

Information to be released **(please check one) ___to __ by:**

Naturopathic Dermatology
Christa Lamothe, ND
Telephone: 425-361-1795
Fax: 425-361-1821
P.O. Box 102
Edmonds, WA 98020

Information to be released (**please check all that apply and SPECIFY DATES**):
___ Chart notes _____
___ Laboratory reports _____
___ Imaging reports _____
___ Pathology reports _____
___ Other **(please specify)** _____

Exclude the following information from the records to be released **(please check all that apply):**
___ Drug abuse
___ Alcoholism or alcohol abuse
___ Testing for or infection with HIV
___ AIDS/AIDS related illness
___ Mental illness or psychiatric treatment

Information to be released for the following purposes **(please check all that apply):**
___ Further care ____ Legal ___ Insurance ___ Personal ___Other: _____

I authorize release of my medical information in accordance with the specifications listed above. I understand that once information is disclosed to the recipient, the recipient may re-disclose this information without my prior consent in the event that the recipient is not a health care provider or subject to federal health privacy laws.
Signature of patient: _____
Signature of parent or legal guardian if patient is a minor: _____
Date: _____