# Authorization to Release Confidential Health Information

## From the Health Record of:

Patient Name: _____ Date of Birth: _____

## I Hereby Authorize:

□ Blue Star Naturopathic Clinic, P.C.
25 NW Louisiana Ave. STE 100, Bend OR 97701
Phone: (541) 389-6935 Fax: (541) 388-4966

□ Facility/Doctor's Name: _____
Address: _____City:_____State:_____Zip:_____
Phone #:_____Fax #:_____

## To Release:

□ Complete Chart Record (*does not include billing information or radiographic images)*
□ Chart Notes: □ All □ Specify: _____
□ Labs / Reports: □ All □ Specify: _____
□ X-rays / Radiographic Images: □ Specify: _____
□ Other: _____

**By initialing below the space(s) below, I am specifically authorizing the release of the following information:**

**_____Medical records from alcohol and/or drug abuse treatment center(s)**
**_____HIV (Human Immunodeficiency Virus) test dates but WITHOUT test results**
**_____HIV (Human Immunodeficiency Virus) test results**
**_____Genetic testing results**

**Restriction Requested:** _____

## To be Released to:

□ Blue Star Naturopathic Clinic, P.C. □ Self (please provide address below)
25 NW Louisiana Ave. STE 100, Bend OR 97701
Phone: (541) 389-6935 **Fax: (541) 388-4966**

□ Facility/Doctor's Name: _____
Address: _____
City: _____State:_____Zip Code: _____
Phone #:_____Fax #:_____

## For the purpose of:

□ Adjunctive/Concurrent 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 that disclosure has already been made in accordance with this document. I understand that if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore, I release, Blue Star Naturopathic Clinic, P.C. or assigns, Laurie Grisez, N.D., Robert Skarperud, N.D., M.S., and employees from all liability arising from this disclosure of my health information.

**Signature:** _____ **Date:** _____ **Signature:**_____
**Patient or Legal Representative** **Witness**