wholehealthshoreline.com
chiropractic

18021 15th Ave NE, Suite 200
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Tel. (206) 524-1330
Fax. (206) 729- 0433

Consent for Release of Confidential Information

I hereby authorize:

☐ Whole Health Chiropractic
☐ 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: _____
☐ Billing Records: ☐ All ☐ Specify: _____
☐ X-Rays/Radiographic Images (Specify): _____
☐ Other: _____

From the health records of:

Name: _____ Date of Birth: ____ / _____ / _____
SSN: _____- _____- _____ Daytime Phone: _____

To be released to:

☐ Whole Health Chiropractic ☐ Self (please provide current address below) ***FEE MAY APPLY***
☐ Facility/ Doctor's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone # _____ Fax # _____

For the purpose of:

☐ Adjunctive/Concurrent Care ☐ Transfer of Care ☐ Other: _____

I understand that this authorization will extend to all aspects of healthcare received.

I release my previous provider from any legal responsibility or liability that may arise from the release of this information. I understand that my health records are protected under federal and state confidentiality laws and cannot be disclosed without my written consent unless otherwise provided for by law.

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

I further acknowledge that this information is given voluntarily and of my own free will.

Signed: _____ Date: _____