HartsSpace
Mental Health & Nutrition

# Authorization to Release Confidential Health Information

## A. I Hereby Authorize:

Katie Hart, MS, CN 2116 Caton Way SW Olympia Wa 98502(360)915-2151 katiehart@hartsspace.com

☑Facility Name:_____ Doctor's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____

## B. To Release:

❑ Complete Chart Record(does not include billing information or radiographic images)
☑ Chart Notes: ❑All ❑Specify: __Regarding _____
**☑Labs/Reports: ❑ All ❑ Specify: ___Blood Lab results – most recent_____**
❑ Billing Records:❑All ❑Specify: _____
❑ X-rays/Radiographic Images(specify): _____
❑ Other:_____

## C. From the Health Records of:

Name: _____ Date of Birth: ____/____/____

Soc. Sec. Number: _____-_____-_____ Daytime Phone: _____ ext: _____
Are you authorizing release of your own records? ❑Yes ❑No
If not, what is your relationship to the patient?_____

## D. To be Released to: FAX 3607542145

☑ Katie Hart, MS, CN 2116 Caton Way SW #102 Olympia Wa 98502 katiehart@hartsspace.com

❑ Self (please provide address below)

❑ Facility Name: _____ Doctor's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone#:_____ Fax #: _____

## E. For the Purpose of:

☑ Adjunctive/Concurrent Care ❑ Transfer of Care ☑ Other: _Medical Nutrition Therapy

This authorization is valid for ninety (90) days from the date signed. I understand that I can revoke this consent at any time, unless disclosure has already occurred in compliance with this consent.

Unless specifically excluded, this authorization includes release of *specially protected information* requiring specific written consent. This includes referral diagnosis and treatment related to substance abuse, mental health conditions and sexually transmitted diseases including HIV (CFR 42, part 2). Release of certain information also requires a *minor's consent.* This applies to persons aged 13 to 17 for information pertaining to substance abuse and mental health information, or persons aged 14 to 17 for information pertaining to sexually transmitted diseases and HIV/AIDS.

I also understand that my information and records are protected under state and federal regulations regarding confidentiality and cannot be released or discussed without my written consent, unless otherwise provided for by law.

I understand that if I request records for personal use, to hand-carry to another health provider, or for parties not involved in patient care, there may be a charge. There is no charge for records mailed directly to another health provider.

'Non-emergency' release of records takes up to 15 working days. 'Emergency' status applies only to release of records directly to another healthcare provider for urgent patient care and will be given priority processing.

**Patient/Guardian Signature** _____ **Date** _____