A Natural Path Integrated Health
Kathleen Flewelling ND
620 S. Holladay Dr, Suite 6 Seaside, OR 97138
P: (503) 738-5859 F: (503) 738-7726

Authorization to Receive and Disclose Protected Health Information

Patient's name: ______________________________ Date of Birth: ____/_____/_____
Patient's address:_____________________________ City/State/ZIP: _______________

I give permission for A Natural Path Integrated Health to _____receive _____disclose (check 1) a copy of the health information listed below to:

Name of Doctor/Facility: ______________________________
Address: ________________________City/State/ZIP: _______________
Phone#: _____________________Fax #______________________

The reason for using this information or giving it out is:
____
____

Information that I give permission to be received or disclosed:

_____ ***The entire record, including those things initialed below:***

(Please put your initials next to the information that can be received or disclosed)

______ Drug/alcohol diagnosis, treatment, or referral information
______ Mental health treatment
______ Genetic testing records
______ Human Immunodeficiency Virus (HIV) or AIDS Information

______ **Only give records for the following information or Date(s) of Service:** _____
(Please put your initials next to the information that can be received or disclosed)

___ Drug/alcohol diagnosis, treatment or referral information	___ Medication list	___ Immunization records
___ Mental health treatment	___ List of allergies	___ Laboratory results
___Genetic testing records	___ Visit/encounter notes	___ Billing records
___ Diagnosis list	___ EKG report	___ History and physical exam
___ Human Immunodeficiency Virus (HIV) or AIDS information	___ X-Ray report	___Other: ____________ ____________

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I understand that if the person or organization that gets this information is not a healthcare provider or health plan covered by Federal privacy laws, the information listed above could be given out by them and will no longer be protected by those regulations. However, I also understand that Federal or State law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol treatment or referral information.

I understand that I may refuse to sign this form, and that I do not need to sign it to receive healthcare, or in order for payment for healthcare to be made. However, if the health care services are going to be provided solely for the purpose of providing health information to someone else and my signature on this authorization is necessary to make that disclosure, I will not receive these health care services if I refuse to sign.

I understand that I may change my mind and decide to cancel my authorization to use and disclose this protected health information at any time. I understand that if I do that, I need to do it in writing, and I will need to send a letter to the person or organization that gave out the information, and who is shown above. I also understand that if I cancel this authorization, the information may have already been received or disclosed before I changed my mind.

I have read this authorization and I understand it. Unless I revoke the authorization sooner, it expires on ______________________________
(Insert the date or the reason that would cancel this authorization.)

______________________________ ___/___/___
Signature of patient, or legal representative Date

____
Printed name of patient or patient's legal representative

____
Legal representative's relationship to the patient

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