Personalized
Lifestyle Medicine Center
by Metagenics

RELEASE OF INFORMATION

By signing and dating this Release of Information, I authorize the identified individuals and agencies involved in my care to share specific information, as checked, about my health. I understand that this is a cooperative effort to share information that will be used to coordinate my care or for other such purposes as authorized below.

PATIENT INFORMATION:

_____ _____
Name Date of Birth

_____
Address

_____
City State ZIP Code

ORGANIZATIONS THAT WILL BE SHARING INFORMATION:

	Name	Address	City	State	ZIP Code
1.					
2.					
3.					

(Use additional forms as necessary)

HEALTH INFORMATION TO BE SHARED
Copies of my health information within the following dates: _____ to _____

The information to be disclosed (shared) is:
_____All Records

Or is to be limited to:

_____Discharge Summary
_____Inpatient Progress Notes
_____Operative Reports
_____Immunizations
_____X-Ray/Imaging Reports
_____Legal issues/concerns
_____Emergency Department Reports
_____Laboratory/Pathology reports
_____Outpatient Visit (Office) Notes
_____School physical forms
_____Lab Work

9770 44th Avenue Northwest, Gig Harbor, Washington, 98332 Phone: 253.853.7233 Fax: 253.851.3923

_____Other (specify)_____

_____Records from the following provider: _____

For the following purpose:

_____Continuity of Care

_____Other; please specify: _____

SENSITIVE HEALTH INFORMATION

I understand and agree that this information will be sent to the PLMC UNLESS I place my initials in the applicable space next to the type of records:

_____Mental health treatment records

_____Genetic testing

_____Sexually Transmitted Disease (STD) treatment records

_____HIV/AIDS test results

_____Alcohol/Drug abuse treatment records

This consent to release is valid for one year, or until otherwise specified, and thereafter is invalid. Specify date, event, or condition on which permission will expire: _____

_____

I or my Personal Representative may revoke this authorization at any time by providing notice as specified in the sending provider's Notice of Privacy Practices; however, my revocation will not apply to any previously released information.

Once this information is shared with the recipient(s) I have specified above, how that recipient further discloses it may no longer be protected. I understand that my records may no longer be protected under applicable federal and state privacy regulations after they are produced.

I understand that PLMC and the health care providers or organizations listed above will not condition my ability to receive healthcare services on providing or refusing to provide this authorization.

A copy of this form is valid to give my permission to disclose records. I understand that my sending health care provider or sending organization may require fees to process this request.

_____ _____

Signature of Patient Date

_____ _____

Signature of Guardian or Responsible Party Date Signature of Witness Date

_____ _____

Name of Guardian/Responsible Party Witness Name

_____

Guardian/Responsible Party Relationship to Patient