Dr. JoAnna Forwell, N.D.
Vitalia Holistic Health Center
1836 Westlake Ave N. Ste 201
Seattle, WA 98109

Authorization to Request Confidential Medical Records

I hereby authorize:
Dr. JoAnna Forwell, N.D.
Vitalia Holistic Health Center
1836 Westlake Ave N. Ste 201
Seattle, WA 98109
Phone: 206. 729. 6100 Fax: 206. 352. 9198

To release Information from the health records of:

Name:_____
Date of Birth:_____SS#_____
Daytime Phone:_____Home Phone:_____

Record to be released to:

Facility/Doctor Name:_____
Address:_____ Phone:_____
City/State/Zip:_____ Fax:_____

Information to be released:

_____ Copy of Health Records
_____ Reports
_____ Lab Results (specify) _____
_____ X-Ray reports and or films (specify)_____
_____ Other (specify)_____

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

Unless specifically excluded, this authorization includes release of specially protected records requiring specific written consent. This includes referral to, diagnosis of and treatment of substance abuse, mental health conditions and sexually transmitted diseases including HIV (CFR 42, pt 2). Certain records also require a minor's consent. This applies to persons aged 13 to 18 for records pertaining to substance abuse and mental health records, or persons aged 14 to 18 for records pertaining to sexually transmitted diseases and HIV/AIDS.

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

Patient/Guardian Signature_____Date_____

Minor/Witness Signature_____Relationship to Patient_____