Peninsula
Naturopathic
Clinic

5603 38th Avenue Northwest
Gig Harbor, Washington 98335
T (253) 857-5544 F (253) 857-9088

Medical Records Release and Statement of Confidentiality

Name: ______________________________ Social Security #: ____________________

Street Address: ____

City: ______________________________ State: __________ Zip Code: ______________

Telephone: (________) ______________________ Date of Birth: ____________________

I authorize ______________________________ to release of the following medical information to the following physician at Peninsula Naturopathic Clinic, PS: ☐ Dr. Steven Davis ☐ Dr. Anna Colombini

☐ Chart notes ☐ Labs ☐ Imaging studies
☐ Hospital reports ☐ History ☐ Other

This authorization covers my care given from ____________________ to ____________________
(Date) (Date)

This information is being released for the following purpose:

☐ Continuing medical care ☐ Insurance billing ☐ Other

I authorize ______________________, ____________________ to pick up the above records.
(Name) (Relationship)

I may revoke this authorization at any time by notifying Peninsula Naturopathic Clinic, PS or other authorized health care providers or clinics in writing. I agree that a photocopy of this authorization may be considered a valid authorization.

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), sexually transmitted disease, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. I release the health care provider(s) and their staff from all legal responsibility or liability that may arise from the release of this information. This consent and release expires 120 days from the date below.

I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment. I understand that revocation will not apply to information that has already been released in response to this authorization. Additionally, I realize that there is potential for my confidential information to be redisclosed by the recipient and thus it would no longer be protected under this privacy rule.

______________________________ ______________________________
(Signature of patient/legal representative) (Date)

______________________________ ______________________________
(Relationship, if other than the patient) (Telephone number)