Chad Aschtgen, ND, FABNO
Erica Joseph, ND, L.Ac, FABNO
Jenna K. Bailey, ND, FABNO
Meghan Zech, ND, FABNO
Jessica N. Harrigan, ND, L.Ac.

Authorization to Release Confidential Health Information

I Hereby Authorize:

☐ *Seattle Integrative Oncology* (including by granting access to my electronic medical/health record)

☐ Other Facility/Physician: _____

Address: _____

City: _____ State: _____ Zip: _____ - _____

Phone: _____ Fax: _____

To Release:

☑ Chart Notes: ☐ All *or* ☑ Specify: **Initial oncology note and most recent follow up note only**

☑ Labs/Reports: ☐ All *or* ☑ Specify: **Last 60 days only; plus history of tumor marker(s) if available**

☑ X-rays/Radiographic Images (specify): **Reports for last 90 days only**

☑ Other: **Initial pathology report if available**

From the Health Records of:

Patient's Name: _____ Date of Birth: _____

Soc. Sec. Number: _____ Daytime Phone: _____ Ext: _____

Are you authorizing release of your own records? ☐ Yes ☐ No; relationship to the patient: _____

Release of certain medical information 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 STDs, HIV and AIDS.

To be Released to: ☐

☐ Chad D. Aschtgen, ND, PLLC at
Providence Integrative Cancer Care
4525 Third Ave SE, Ste 200
Lacey, WA 98506
t: 360. 754.3934; 1083 | f: 360.412.8955

☐ Chad D. Aschtgen, ND, PLLC at
Seattle Integrative Oncology
2859 Eastlake Ave E
Seattle, WA 98102
t: 206-739-7447 | f: 844-883-0052

☐ Other: _____

For the Purpose of:

☑ Concurrent Care ☐ Transfer of Care ☐ Other: _____

I understand that unless revoked this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document. **Unless specifically excluded**, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to: (Check box(s) below to **EXCLUDE** the information)

☐ **Substance abuse** ☐ **Mental health conditions/Psychotherapy** ☐ **Sexually transmitted diseases** ☐ **HIV/AIDS**

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected. I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing. I may contact *Seattle Integrative Oncology* at 206.739.7447 to inquire about revoking authorization.

_____ _____

Print Patient's Name *Patient's Signature Date*

_____ _____

Print Name of Guardian or Responsible Party *Signature of Guardian/Responsible Party* *Date*

OFFICE ONLY: Date Sent: ____/____/____ By Staff: _____