Release of Information Request
Pacifica Medicine & Wellness

Patient Authorization: **Last name:** **First name:** **MI:**

Date of Birth: [ ] Male [ ] Female [ ] Non-Binary

Home address Street:

City: State: Zip: Phone number:

Records to be sent FROM ☐ **TO** ☐ **(Mark X for intended direction)**

Facility or Provider Name:

Phone: ( ) Fax: ( )

Address: City: State:

Records to be sent TO ☐ **FROM** ☐ **(Mark X for intended direction)**

Name: **Pacifica Medicine & Wellness** Phone: **(360) 979-0569** Fax: (**877**) **805-9505**
Address: **PO Box 2940** City: **Poulsbo** State: **WA** Zip: **98370** **Provider:** _____

Purpose of Disclosure:
[ ] Continuing care [ ] Insurance [ ] Legal [ ] Personal Use [ ] Transfer of Care [ ] Other (please specify):

Records to Include:
This authorization pertains to the disclosure of the record types indicated below for **the past 2 years**:
[ ] ALL records retained by the facility.
[ ] Progress Notes [ ] Laboratory results [ ] Immunization Records [ ] Operative reports [ ] Hospital Records
[ ] Imaging Reports [ ] Other specified information:

Disclosure of Sensitive Information:
I understand that my health record may contain sensitive information related to my condition(s). This includes, but is not limited to, information pertaining to sexually transmitted disease, HIV/AIDS, behavioral or mental health services and treatment for alcohol and drug abuse.
By checking this box, I chose to *exclude* the above types of information from this disclosure. [ ]

Terms and Conditions:
- I have the right to revoke this Authorization, in writing, at any time by notifying Pacifica Medicine & Wellness and the healthcare provider being requested to disclose the health information (if applicable). Such revocation will not apply to information that has already been disclosed in reliance on this Authorization.
- I have the right to not sign this Authorization. Pacifica Medicine & Wellness will not condition treatments, payments for services, or enrollment or eligibility for benefits on whether or not I sign this Authorization.
- If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is the potential for this information to be subject to re-disclosure and no longer be protected by these laws.
- I have read and understand this Authorization, have had an opportunity to have my questions answered, have signed this Authorization freely and have received a copy of this Authorization.
- Please note, this Authorization expires one (1) year after the date of signature unless otherwise specified: _____
- I understand that submitting this Authorization to Pacifica Medicine & Wellness will not terminate my membership and that I will continue to be billed for services until I submit a Service Cancellation Form to Pacifica Medicine & Wellness.

ACCOUNT HOLDER SIGNATURE: _____ **DATE:** / /

PRINT NAME: _____

SIGNATURE BY: **[ ] Patient** **[ ] Parent** **[ ] Legal Guardian**