



WHIDBEY ISLAND NATUROPATHIC

CONFIDENTIAL MEDICAL INFORMATION RELEASE/REQUEST

I hereby authorize:

Facility Name/Doctor: _____

Mailing Address: _____

Phone/Fax: _____

To release from the health records of:

Patient Name: _____

Date of Birth: _____

SSN: _____

Daytime Phone: _____

The following information:

Copy of Complete Health Record

Lab Results

Other: _____

Dates of treatment:

From: _____ To: _____

Information to be released to:

Dr. Thomas Rogers Dr. Alicia Capsey

**Whidbey Island Naturopathic
840 SE Bayshore Dr., Suite 201
Oak Harbor, WA 98277
(360) 679-8946 Fax 675-6140**

I understand that some of the information released may include diagnosis and/or treatment of AIDS (HIV virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental health status or psychiatric treatment. Further release of this information to other parties cannot be done without my authorization. I hereby release the practitioner/s and associated staff from legal responsibility that may arise from the act hereby authorized.

Patient signature: _____ **Date:** _____