Dr. Peter Knight
Your Naturopathic Health Partner

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name:_____ Date of Birth: _____

USE THIS AREA IF YOU WANT DR. KNIGHT TO SEND YOUR RECORDS TO SOMEONE ELSE

I authorize Dr. Peter Knight to release my medical records to:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

***USE THIS AREA IF YOU WANT SOMEONE ELSE TO SEND YOUR RECORDS TO DR. KNIGHT ***

I authorize the below to release my records to Dr. Knight.

Name:_____

Address: _____

Phone #: _____ Fax #: _____

Records are to be used for:

____ Consultation ___ Transfer of Care ___Personal file ___Legal or disability ___Other (specify:_____)

What information do you want sent?

___ All information, including history, dates, course and outcome of treatment (most common choice)
(Indicate approximate dates:_____)
___ Lab results only (Indicate approximate dates:_____)
___ Progress notes only ____Consult report only ___ Other:_____

You have the right to limit the release of sensitive information. **If you have been tested, diagnosed, or treated for any of the following, the Releasor needs your specific consent to release those portions of your medical record. You also have the right to review any such records before they are disclosed.**

PLEASE INDICATE:

__ None of these things apply to me/no limitations on information release.

OR (indicate any which apply)

__I do ***not*** authorize disclosure of information regarding HIV testing and results.
__I do ***not*** authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol use.
Such information may not be re-disclosed by the recipient without my specific written consent.
__I do ***not*** authorize disclosure of information which refers to treatment or diagnosis of psychiatric illness.
__I do ***not*** agree to have such information released without my prior review

I understand the following: I can refuse to disclose some or all of the information in my treatment records, but if I do so, it could result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences; I can revoke all or part of this authorization, in writing, at any time by delivering a written, dated, and signed notification to Dr. Knight except to the extent that Dr. Knight has already acted in reliance on it; I am entitled to a copy of this authorization, upon request; I can cross out any provision on this form with which I disagree; Recipients may not be subject to state and federal Privacy laws and therefore information may be re-disclosed without my consent.

This authorization is effective until for 12 months from the date below unless I specify otherwise. I authorize future disclosures regarding these records to the same individuals and/or entities during this time period.

Signature of patient or legal representative Date Relationship (i.e., self, parent)