

Martin Ross, M.D.
Tara Nelson, N.D.
The Healing Arts Partnership
4744 41st Ave. S.W., Ste. 102; Seattle, WA 98116
PH: 206-932-0880 FAX: 206-932-3738

Authorization to Use or Disclose My Health Care Information

Patient Name: _____ Date of Birth _____

Previous Names: _____

1. I authorize Dr. Martin Ross, M.D. or Dr. Tara Brooke Nelson, N.D.:

You may use or disclose the following health care information (check all that apply):

- All health care information in my medical record including section 1A.
- Health care information in my medical record relating to the following treatment or condition: _____
- Health care information in my medical record for the date(s): _____
- Other (e.g., X rays, bills, specify date(s)) _____

1A. You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply).

- HIV (AIDS virus) Psychiatric and mental health disorders
- Sexually transmitted diseases Drug and/or alcohol use

Reasons for this authorization (check all that apply):

- At my request
- Other (specify) _____
- This authorization ends (Date) _____ (this document does not permit disclosure of health information created more than 90 days after the date it is signed)
- When the following event occurs _____
- So that I may receive copies of my health care records while in care at this clinic.

2. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign and authorization form:

To take part in a research study or

To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Martin Ross, M.D. or Tara Brooke Nelson, N.D. and The Healing Arts Partnership based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. If you wish to revoke this authorization, please send your written request to the address above and the appropriate provider. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

You May disclose this information to: _____

Patient or legally authorized Individual signature

Date

Print name if signed on behalf of the patient

Relationship