Donna Kachinskas, PhD, ND

18047 NE 68th St, Ste B-100
Redmond, WA 98057
Tel: 425-217-7788 FAX: 425-883-1700

Authorization to Request Confidential Medical Records

I hereby authorize:

Facility and/or Physician's Name_____
Address _____ Phone _____
City/State/Zip _____ Fax _____

To release information from the health records of:

Name _____
Date of birth ____/____/____ Patient ID/Social Sec. Number _____
Day Phone _____

Information to be released:

____ Copy of Complete Health Records ____ Billing information
____ Medical Reports Only ____ Pathology Reports
____ Lab Results Only (specify) _____
____ X-ray or Imaging Report (specify) _____
____ Other (specify) _____

Dates of treatment requested: _____

Information is to be released to:

Donna Kachinskas, Ph.D.,N.D.
18047 NE 68th St, Ste B-100
Redmond, WA 98057
Tel: 425.217.7788 FAX: 425.883.1700

My rights: I understand I do not have to sign this authorization to receive health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study.
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing according to patient privacy procedures. Once Dr. Serena McKenzie has disclosed health information, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information. I understand that this authorization does not permit the release of information related to health care provided to me more than ninety days after the date of this authorization. This prohibition does not extend to insurance companies.

Patient/Guardian signature _____ Date _____

Minor/Witness _____ Relationship to Patient _____

Office Use Only
Date Sent ___/___/___