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T: 206-355-6781
F: 206-365-0663

13433 NE 20th St. #D
Bellevue, WA 98005
T: 425-451-4301
F: 425-957-1406

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Monroe, WA 98272
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KHESIN CLINICAL MASSAGE & REHABILITATION

CLINICAL MASSAGE & MANUAL THERAPY
SPECIALIZING IN PAIN & HEADACHE MANAGEMENT

Authorization to release medical records/health information

Name:_____ Date:_____

Social security #/ID #: _____ Birth date:_____

I_____ authorize _____

To disclose, release, receive and/or discuss my health records and/or pertinent information

To / From: Name: _____

Address: _____

Phone/Fax _____

The information being released includes the following (please check one):

____ **All health care information** (which included all information regarding medical and psychiatric issues, mental health, drug and alcohol use/abuse and information about sexually transmitted diseases.

____ **Information limited to the following:**

I am aware of and expect that all information is confidential and is protected by the policies of confidentiality of this office and by state and federal regulations. I know that I can revoke this authorization at any time by giving the office a statement in writing that is signed and dated.

This authorization ends in 90 days and can be renewed by the patient by initialing and dating next to the new start date.

I understand there may be a fee associated with the preparation of my records.

Signature of patient or authorized representative_____ Date_____

Rev: 6/18/2010