NORTHWEST
WEIGHT & WELLNESS CENTER

Authorization to Use or Disclose My Health Care Information

Patient Name: _____ Date of birth: _____

Previous Name: _____

I hereby request:

Facility Name: _____ Provider: _____

Address: _____ Phone: _____

City/State/Zip: _____ Fax: _____

To release my medical records in their possession to:

Northwest Weight & Wellness Center
125 130th Street SE, 1st Floor
Everett, WA 98208

Phone: 425-224-8200
Fax: 425-224-8299

In the form of record copies and professional communication (written/oral) about the above patient.

Please send the following information:

- ☐ All medical records
- ☐ Most recent 2 years of records
- ☐ Specific Records (please list below)

_____
_____
_____

I hereby consent to the release of the above information including records of HIV disease, sexually transmitted disease, mental illness, and drug or alcohol abuse. You are authorized to release to Northwest Weight & Wellness Center all information or medical records relating to diagnosis, testing or treatment for these and other diseases. I understand such information cannot be released without my informed consent. This authorization shall be valid for 365 days from the date of signing unless rescinded in writing. I have received a copy of this authorization. I understand that I do not have to sign this authorization to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) RCW 43.70.510

_____ _____
Signature of patient/legally authorized individual Date

_____ _____
Printed name of patient/legally authorized individual Relationship to Patient (if applicable)