TRINITY NATURAL MEDICINE & ACUPUNCTURE (TNMA)
6505 218TH ST. SW, STE 15
MOUNTLAKE TERRACE, WA 98043
(425) 582-2081

HIPAA MEDICAL RECORDS RELEASE FORM

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following using or disclosing party:
☐ - Trinity Natural Medicine & Acupuncture
☐ - Other Facility _____
Doctor/healthcare provider _____
Address _____
City, State, Zip _____
Phone _____ Fax _____

To use or disclose the following health information:
☐ - ALL of my health information / medical records
☐ - My medical records relating to the following treatment or condition(s):
_____
☐ - My medical records covering the period from _____ (date) to _____ (date)
☐ - Other: _____

The above party may disclose this health information to the following recipient(s):
☐ - Trinity Natural Medicine & Acupuncture
☐ - Other Facility/Organization _____
Address _____
City/State/Zip _____
Phone _____ Fax _____
☐ - Self (patient) _____
☐ - Other individual _____

The purpose of this authorization is (check all that apply):
☐ - At my request / personal records
☐ - For the transfer of medical care to another medical provider or healthcare facility
☐ - Other: _____

This authorization ends:
☐ - On (date)_____
☐ - After _____ days

www.trinitynma.com
Email: 3team@trinitynma.com
Fax: (425) 678-0430

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

X Signature of Patient: _____ **Date:** _____

If the patient is a minor or unable to sign, please complete the following:
☐ - Patient is a minor: _____ years of age
☐ - Patient is unable to sign because: _____
Print Name of Authorized Representative: _____
Authority of representative to sign on behalf of the patient:
☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

X Signature of Authorized Representative: _____ **Date:** _____

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**.
*Separate consent must be given before this information can be released.
☐ - I consent to have the above information released.
☐ - I do not consent to have the above information released.

X Signature of Patient or Authorized Representative: _____
Date: _____

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**.
*Separate consent must be given to have this information released.
☐ - I consent to have the above information released.

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☐ - I do not consent to have the above information released.

X Signature of Patient or Authorized Representative: _____
Date: _____

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