

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to

release healthcare information of the patient named above to:

Lifespring Cancer Treatment Center
2825 Eastlake Avenue East,
Suite 200
Seattle, WA 98102

Phone#: (206) 686-1266
Fax #: (206) 686-1268
Email: HealthInfo@lifespringcancer.com

This request and authorization applies to:

ü Healthcare information relating to the following treatment, condition, or dates: _____

ü All healthcare information

ü Other: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

Signature: _____ Date Signed: _____
(patient or patient's authorized representative)

Relationship / status: _____
If signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

This authorization expires 90 days after the date it is signed.