RED-ROSE **CHIROPRACTIC CLINIC, P.S.**

12841 NE 85TH STREET • KIRKLAND, WA 98033 • (425) 893-9200 • fax (425) 893-8046

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby request that my medical records be released to:

____ RED-ROSE Chiropractic Clinic

____ Myself

____ Other _____

I ask: _____

_____

_____

to furnish all requested medical information to the person or entity names above. I understand that my express consent is required for the doctor to release information relating to sexually transmitted disease, AIDS or HIV, mental illness, and drug or alcohol abuse pursuant to Washington Law RCW 70.24 Et. Seq.

If I have been tested, treated or diagnosed in connection with any sexually transmitted disease, AIDS or HIV, drug or alcohol abuse, and/or mental illness, your are **specifically authorized to release** to the person or entity names above all information or medical records relating to such diagnosis, testing or treatment unless specifically excluded below.

_____

I understand that the doctor from whom I request records cannot limit or control the subsequent use or dissemination of medical information by the party to whom I request the information be furnished. This request is free and voluntary act by me. I hereby release the doctor from whom this request is made and his staff from all legal responsibility that may arise from the release of the medical information herby authorized.

Specifically Include:

Medical Records	( )
X-Ray Film or MRI	( )
Other	( )

Patient Name (print): _____

Patient Name (signature): _____ Date: _____

Date of Birth: _____

If patient is under 18 years of age, a parent or legal guardian signature is required.

Name: _____ Signature: _____ Date: _____