Basalt Family Wellness
700 E Mountain View Ave, Ste 505
Ellensburg, Washington, US - 98926

****Records Release to Basalt Family Wellness

Patient Name: _____

Patient DOB: _____

Information to be released to:

- ☐ Macy Schorno, ARNP, at Basalt Family Wellness 700 E Mountain View Ave, #505, Ellensburg, WA 98926, p. 509-426-3750, f. 509-426-3760

Information to be released from:

- ☐ Sky Valley Family Wellness, 2302 W Dolarway Rd, Suite 2, Ellensburg, WA 98926, p. 509-219-0413 f. 509-762-9143
- ☐ Other: Please write in information

Information to be Released:

- ☐ Complete medical records
- ☐ Other specific information (please specify below)

Purpose for which disclosure is being made:

- ☐ Transfer of Care

Patient Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drugs and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. *Exclude the following information from the records released:

- ☐ Substance abuse treatment/ diagnosis
- ☐ HIV/ AIDS diagnosis/ treatment/ testing
- ☐ Sexually Transmitted disease
- ☐ Psychiatric diagnosis/ treatment

MY RIGHTS:

I understand I have a right to revoke this authorization at any time. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, which by law provides my insurer with the right to contest a claim under my policy. This authorization will expire after 1 year.

PATIENT or GUARDIAN SIGNATURE _____

Printed Name of SIGNER (and relationship to patient if not signed by patient): * _____