

Samia McCully, ND • Wellness Architecture Inc.  
841 El Camino Real  
Menlo Park, CA 94025

## Authorization to Release Confidential Health Information

### I Hereby Authorize:

- Samia McCully, ND  
 Facility/Doctor's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_  
Phone#: \_\_\_\_\_ Fax #: \_\_\_\_\_

### To Release:

- Complete Chart Record (*does not include billing information or radiographic images*)  
 Chart Notes:  All  Specify: \_\_\_\_\_  
 Labs/Reports:  All  Specify: \_\_\_\_\_  
 Billing Records:  All  Specify: \_\_\_\_\_  
 X-rays/Radiographic Images(specify): \_\_\_\_\_  
 Other: \_\_\_\_\_

### From the Health Records of:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc.  
Sec. Number: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ ext.: \_\_\_\_\_

Are you authorizing release of your own records?  Yes  No

Release of certain medical information requires a minor's consent. This applies to persons aged 13 to 17 for information pertaining to substance abuse and mental health information, or persons aged 14 to 17 for information pertaining to sexually transmitted diseases, HIV and AIDS. Other laws may apply.

### To be Released to:

- Samia McCully, ND  Self (please provide address below if requesting a copy of your own records)  
 Facility/Doctor/Family Member: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Fax#/EmailAddress: \_\_\_\_\_

### For the Purpose of:

- Adjunctive/Concurrent Care  Transfer of Care  Other: \_\_\_\_\_

I understand that unless revoked this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.

**Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to:**

**(check the accompanying box(s) below to EXCLUDE the information from authorization)**

- substance abuse  mental health/psychotherapy notes  sexually transmitted diseases and  HIV/AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.

I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing. I may call 650-233-7327 to inquire about revoking this authorization.

I understand that I am financially responsible for the cost of copying and obtaining my medical records for the purpose of my own viewing.

\_\_\_\_\_  
Guardian/Personal Representative's Name (PRINT)

\_\_\_\_\_  
Patient's Name (PRINT)

\_\_\_\_\_  
Guardian/Personal Representative's Signature

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Relationship/Representative's Authority

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date