206.257.5817 PH
206.257.5819 FAX
105 NE 56th Street
Seattle, Washington 98105
www.tilianaturalhealth.com

Authorization to Disclose My Health Care Information to Tilia Natural Health, LLC

Patient name:____Date of birth:___________________

Previous name:____SS#:_________________________

Address:_________________________________ City:_____________State:_______Zip Code:_________

My Authorization:

I hereby request and authorize: (facility/Dr)____

at (location)___________________________________**(fax #)**___________________________________

to disclose the following health care information (check all that apply):

- □ All health care information in my medical record
- □ Health care information in my medical record relating to the following treatment or condition: ______________
- □ Health care information in my medical record for the date(s): ______________________________________
- □ Other (e.g., X rays, bills, all diagnostic labs and imaging), specify date(s): _____________________________

You may disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- □ HIV (AIDS virus)
- □ Psychiatric disorders/mental health
- □ Sexually transmitted diseases
- □ Drug and/or alcohol use

You may disclose this health care information to:

Tilia Natural Health
105 NE 56th Street
Seattle, WA 98105
ANY Records sent via CD must be MAC-compatible

Phone – 206-257-5817
FAX – 206-257-5819
frontdesk@tilianaturalhealth.com

This authorization ends:

- □ Ongoing for the purposes of collaborative care
- □ 90 days from the date signed
- □ On (date) ____________
- □ When the following event occurs ________________________________

My Rights

I understand I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form in order to receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by my provider based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Tilia Natural Health, or
- Write a letter to my provider revoking the authorization

Once health care information is disclosed, the person or organization that receives it may re-disclose it, at which point Tilia Natural Health no longer has control over that distribution.

____ ____________________
Patient or legally authorized individual signature Date

____ ____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)