CuraDirect
Healthcare

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Authorization for Release of Medical Records from CuraDirect Healthcare

Patient information:

Name:

DOB:

Information to be released from:

Facility: CuraDirect Healthcare

Provider: Wendy N Magana DNP ARNP FNP-BC

Address: 5205 S 2nd Ave, STE G & H, Everett, WA 98203

Information to be sent to:

Name of facility or provider:_____

Address:_____

Phone number:_____

Fax #:_____

Information to be released (check one):

☐ Health Summary (Medical history, allergies, medications, social history, family history, last vitals, preventative screenings)

☐ Last chart note and vitals ☐ Most recent 2 years of chart notes

☐ Most recent 2 years of labs & imaging

☐ Most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests)

☐ All medical records

Specific information (please specify)

_____

Patient Authorization:

I expressly authorize and consent for CuraDirect Healthcare to release medical records or disclose protected health information to the listed healthcare provider, facility or entity.

I expressly authorize and consent to the disclosure of my health information related to (circle all that apply):

☐ Alcohol and substance use ☐ Mental health ☐ Sexually transmitted infections including HIV/AIDS

☐ Genetic testing/counseling

Medical records are maintained to serve the patient and the healthcare team in accordance with all applicable legal and regulatory requirements. The information contained in medical records is considered highly confidential. All patient care information shall be regarded as confidential and available only to authorized users. The phrase "medical records" includes any protected health information (PHI), which includes test results, any medical reports, the medical record itself, claim files, and any correspondence related to the care of a patient. Any disclosure of my protected health information to a different name, class of person, address, or fax number will require a separate authorization.

I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization. For the revocation of this authorization to be effective, the name(s) or class of person(s) must receive the revocation in writing.

This authorization shall expire one year from the date signed after one year, a new authorization form is needed to continually disclose PHI. I understand this authorization is voluntary and I may refuse to sign it. I fully understand the and accept the terms of this authorization. A copy of this authorization is valid as an original.

Patient (or Authorized Representative) Signature	Date