

**Narrows Natural Health Clinic**

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**Date:** \_\_\_\_\_

**To be released from:** \_\_\_\_\_

**Fax #** \_\_\_\_\_

Fax **ASAP**     Fax     OK to mail

**This Request and Authorization Applies to:**

- All healthcare information
- Diagnostic Imaging Reports to include X-rays, MRI's, Ultrasounds, \_\_\_\_\_
- Original X-rays, MRI's, Ultrasounds with Reports \_\_\_\_\_
- Labwork
- Healthcare information relating to the following condition only \_\_\_\_\_
- Other \_\_\_\_\_

**Federally Protected Information**

Unless otherwise noted, I specifically authorize the release of information pertaining to testing, diagnosis, and/or treatment of psychiatric disorders/mental health, alcohol /drug use and sexually transmitted diseases including HIV/AIDS, if such is part of my record.

*Excluded information:* \_\_\_\_\_

**Name:** \_\_\_\_\_                      **Birthdate:** \_\_\_\_\_  
*(Patients name, printed)*

**Signature:** \_\_\_\_\_                      \_\_\_\_\_  
*(Of legally Responsible Person)*                      *(Relationship to Patient)*

**Date:** \_\_\_\_\_

*This Consent Expires 90 Days From Date Of Signature*