INTEGRATIVE HEADACHE CLINIC

Mark Piker, MD
Board Certified Neurologist

4140 Factoria Blvd SE Ste A
Bellevue, WA 98006

tel 425.655.0700
fax 425.655.0800

www.ihclinic.org
email@ihclinic.org

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

First and Last Name _____ Date of Birth _____ Phone _____

I, _____, hereby authorize the release, disclosure, and use of my medical information as follows:

PURPOSE OF RELEASE:

☐ Insurance ☐ Personal ☐ Treatment Elsewhere ☐ Transfer of Care ☐ Legal ☐ OTHER:

_____

I authorize Mark Piker, MD (Integrative Headache Clinic) to release my medical information to the following organizations and/or individuals:

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

The following information may be released:

☐ COMPLETE RECORD ☐ Out-Patient Notes ☐ Consultation Notes ☐ Progress Notes ☐ Emergency Department Records

☐ Inpatient Notes ☐ Surgical/Operative Notes ☐ Discharge Summaries ☐ Mental Health/Psychiatric Records

☐ Medications/Pharmacy Records ☐ Laboratory Results ☐ Studies/Tests Results ☐ OTHER:

_____

I authorize the following organizations and/or individuals to release my medical information to Mark Piker, MD (Integrative Headache Clinic): ☐ Same as above

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

The following information may be released:

☐ COMPLETE RECORD ☐ Out-Patient Notes ☐ Consultation Notes ☐ Progress Notes ☐ Emergency Department Records

☐ Inpatient Notes ☐ Surgical/Operative Notes ☐ Discharge Summaries ☐ Mental Health/Psychiatric Records

☐ Medications/Pharmacy Records ☐ Laboratory Results ☐ Studies/Tests Results ☐ OTHER:

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified medical information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I have the right to inspect the health information to be released, and I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAAs privacy rules after the authorized disclosure.

I release Mark Piker, MD (Integrative Headache Clinic) as well as its agents and employees from any liability in connection with the use or disclosure of the medical information covered by this authorization.

I understand that I may revoke this authorization at any time by providing written notification to Mark Piker, MD (Integrative Headache Clinic). The revocation will be effective on the date it has been received and processed by the above-named recipient. Any request for revocation will not apply to information already used or disclosed pursuant to this authorization.

Unless otherwise noticed or revoked in writing, this authorization will expire **one (1) year** from the date on which I signed this authorization.

I request that this authorization expire on _____

Client Name

_____

Representative Name

_____

If Representative

- ☐ Client is a minor or is unable to sign this agreement for other reasons
- ☐ I'm entering into the agreement on behalf of the client as a legally authorized representative of the client

Relationship to Client

○ Spouse ○ Parent ○ Child ○ Sibling ○ Partner ○ Significant other ○ Friend ○ Other

Your signature below indicates that you have read and agree with the terms outlined in this form.

_____ _____

Client or Representative Signature Date