Dr. Jessica "Nikki" Myhre
Fax: 360-282-0785
Email: admin@koruhealthpa.com

Authorization to Release Medical Records

Patient Name: _____

Date of Birth: _____Previous Name (if applicable): _____

Information to be released to:

Name (Facility or Provider: _____

Phone Number: _____Fax Number: _____

Address: _____

Information to be sent from:

Jessica (Nikki) Myhre, DO

Fax: (360) 282-0785

Email- admin@koruhealthpa.com

Information to be released:

☐ The most recent 2 years of pertinent information (chart notes, labs, imaging, special tests, vaccines)

☐ All medical records

☐ Specific information (please specify): _____

Purpose for which the disclosure is being made:

Doctor/Medical/Continuity of Care: _____ Personal: _____ Insurance: _____ Attorney: _____

Dr. Jessica “Nikki” Myhre
Fax: 360-282-0785
Email: admin@koruhealthpa.com

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. EXCLUDE the following information from the records released (please initial):

____ Drug/Alcohol abuse/treatment/diagnosis _____ Sexually transmitted disease
____ HIV/AIDS diagnosis/treatment/testing _____ Mental illness or psychiatric diagnosis/treatment

My rights

I understand I do not have to sign this authorization to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing to the Practice. I understand that once this health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date:_____
(Patient, Guardian, or Authorized Individual)

This authorization expires 90 days from the date signed. Possible copying fee required.