P.O. Box 1732
Snohomish, WA 98291-1732
Phone: (425) 806-4600 Fax: (855) 615-2852

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize New Horizon Hormones/Lauren Schweizer, ARNP to disclose and/or receive **PHI** for:

Patient Name: ____ DOB: __________________

Previous Name Used: _________________________________ Phone # ______________________________

To/From the following Facility/Provider:

Name of Facility/Provider	
Address, City, State	
Phone #	Fax #

(OPTIONAL - PLEASE READ CAREFULLY) Specific information to be **EXCLUDED** from this authorization:
This release **MAY NOT** include specific information related to:

PLEASE INITIAL NEXT TO DESIRED EXCULSIONS IF APPLICABLE:
Testing, diagnosis, and/or treatment for HIV/AIDS _____
Sexually transmitted diseases ______
Psychiatric disorders/mental health ______
Drug and/or alcohol use / Substance Abuse _____

(For office use only) Type of information to be requested and/or received:

___ Lab Results
___ Pap Smear Results
___ Preventative Chart Note
___ Visit/Progress Notes: __________________________
___ DEXA Report
___ Mammogram Report
___ Other: ________________________________

I understand I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. If not revoked, this authorization expires 1 year from the date of signature unless otherwise specified. (RCW 70.02.030) I understand I have the right to receive a copy of this authorization form.

X____ X____________________
Signature of Patient **Today's Date**