Interactive HEALTH CLINIC
Proactive Medicine that Rejuvenates You
16108 Ash Way, Suite 109 Lynnwood, WA 98087 425.361.7945

Medical Authorization Consent Form

I, (patient) _____, authorize my physician, Dr._____, to discuss the allowed medical information listed below, with _____, my _____, when I am not present, as I am over 18 years of age.

- Select Chart notes (yes/no)
- Select Laboratory reports (yes/no)
- Select Imaging (including x-ray, ultrasound, MRI, CT, PET scan) (yes/no)
- Select Supplement or medication dosages and strengths (yes/no)
- Select Billing information pertaining to my account (yes/no)

Additional information I am authorizing to be discussed that is not previously listed:

_____
_____
_____
_____
_____
_____

I confirm I authorize on my own behalf and will contact Interactive Health Clinic if any of this information is to be changed in the future.

Patient Printed Name: _____ Date: _____

Patient Signature: _____ Date: _____