Request for Clinical Records

To request a copy of your clinical records from Opal: Food+Body Wisdom, please complete this Request for Clinical Records form and submit it to the front desk at frontdesk@opalfoodandbody.com. We can only release records that originated at Opal and cannot release records from any outside providers. Please contact outside providers directly if you would like a copy of their records.

Be aware that your treatment notes are written from a medical, clinical perspective with a particular interest in documenting the medical necessity of your care. Detailed clinical notes are taken by clinicians which can include direct quotes related to treatment concerns. Nutrition notes will include quantitative data (i.e., weights, calories, % meal completion, etc.) that may be unhelpful to you. For some, this can lead to a difficult time reviewing records, therefore it is encouraged that you meet with a member of your treatment team to review your records with support.

Would you like to meet with a clinician or a member of your treatment team to review your records? *If Yes*, Opal Front Desk will coordinate with your treatment team to schedule with you.

- ☐ Yes
- ☐ No

Please allow for up to five (5) business days for us to complete this request.

Patient Name:

DOB:

Date Requested:

Who do you want the records released to (self or other):

Name: _____

If you want records released to anyone other than yourself,
please complete the included Release of Information for the other party.

Requested Delivery Method:

- ☐ Fax: _____
- ☐ Email: _____
- ☐ Mail - Address: _____

Records to release:

- ☐ Full clinical record
- ☐ Nutrition Notes
- ☐ Medical Notes
- ☐ Therapy Notes
- ☐ Other: _____

Authorization to Use/Disclose Protected Health Information

I, _____, DOB: _____, give permission to Opal: Food+Body Wisdom to:

☐ mutually exchange the following health information, and/or
☐ mutually exchange the disclosure of the following protected health information with:

Name/s (include specific name, clinic name as appropriate, and role in client's care):

_____

_____

Phone: _____Fax:_____ Email: _____

Information to be disclosed (client: initial all that apply):

☐ Medical records
☐ Mental health treatment records
☐ Nutrition records
☐ Billing (Non-clinical)
☐ Other: _____

This protected health information is being used or disclosed for the following purpose/s:

☐ Coordination of care
☐ Other: _____

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment but could decrease our ability to provide the most effective care due a lack of coordination of care with your other providers. You understand that communication between providers could occur in person, by phone, email, text, and/or video conferencing.

You further understand that Opal staff are mandated reporters and must break confidentiality regardless of your authorization in the case of imminent harm to self or others. In these instances, staff must abide by all state (RCW 70.02.050, 71.05.390, 71.05.630) and federal laws pertaining to confidentiality, including HIPAA. You may revoke this authorization at any time. Your notice will not apply to actions taken by the requesting person/entity prior to the date Opal: Food+Body Wisdom receives your request to revoke authorization.

This release expires 30 days after your discharge for clinical continuity of care purposes. For billing purposes, this release expires once you have paid your balance at Opal in full.

_____ _____

Signature of client Date

Opal: Food+Body Wisdom
1100 NE 45th Street, Suite 600 Seattle, WA 98105
phone: 206.926.9087 fax: 206.632.7685 www.opalfoodandbody.com