LONGEVITY MEDICAL CLINIC™

Feel Younger · Live Better

PATIENT CONTACT INFORMATION

We require all new patients to present photo ID. If photo ID does not contain current address, a form of mail correspondence with name & current address is accepted.

Name (First, MI, Last): Rose A Kuhlman

Billing Address:

Street: 4618 Old Machias Rd

City: Snohomish State: WA Zip Code: 98290

Shipping Address (if different from billing address):

Street: SAME

City: State: Zip Code:

Phone Numbers: Please check your contact preference.

Home: Preferred ☐
- ☐ Authorized to leave detailed information
- ☐ Leave call back number only
- ☐ Do not leave message

Work: Preferred ☐
- ☐ Authorized to leave detailed information
- ☐ Leave call back number only
- ☐ Do not leave message

Cellular: 425-760-4069 Preferred ☒
- ☒ Authorized to leave detailed information
- ☐ Leave call back number only
- ☐ Do not leave message

Fax:
- ☐ Authorized to leave detailed information

Email: mikesgal53@yahoo.com

Date of Birth: 9/25/1953 **Gender:** ☐ Male ☒ Female

Emergency Contact:

Name: Mike Kuhlman

Address: Same as above

City: State: Zip Code:

Phone: 425-231-3000 Relationship: Spouse

Are you on Medicare Part B? ☒ Yes ☐ No

Signature: Rose Kuhlman **Date:** 11-12-19

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AUTHORIZATION FOR RELEASE OF INFORMATION OF MEDICAL RECORDS

Patient Name: Rose Kuhlmar

Address: 16180 Old Machias Rd Snohomish WA 98290

SSN: 538-68-1791 Date of Birth: 9-25-2019

Name of Clinic or Physician: _____

Address: _____

Phone: _____ Fax: _____

I authorize the above-named individual or organization to disclose the above named patient's health information as described below, to the following recipient: **Longevity Medical Clinic Copies of all responsive documents should be mailed to the following address: 19221 36th Avenue West, Suite 210, Lynnwood, WA 98036 or faxed to (425) 670-1002, for continuing medical care.**

INFORMATION TO BE RELEASED

- Current CBC, CMP, Cholesterol and any hormone testing. For men, last PSA.
- Current History and Physical.
- For women, current PAP report and mammogram report.
- Current colonoscopy report.

Information obtained from the above-named individual or organization shall not be disclosed to anyone other than representatives of Longevity Medical Clinic to conduct a personal review of disclosed information and to orally discuss this information to develop a plan of care at Longevity Medical Clinic. I understand that the information provided may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.

I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be re-disclosed.

REVOCATION: I have the right to revoke this release authorization at any time. The revocation must be in writing and be delivered to Longevity Medical Clinic, at the address set forth above. The revocation will not apply to records and information that have already been provided.

EXPIRATION: This authorization will expire when the request has been filled. PHOTOCOPIES OF THE AUTHORIZATION ARE VALID AND MAY BE USED IN LIEU OF THE ORIGINAL.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize to use or disclose my health information in the manner described above.

_____ _____

Patient / Legal Representative Signature Date