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AUTHORIZATION FOR THE RELEASE OF INFORMATION

Patient Name: _____ Patient Date of Birth: _____

I, _____ hereby authorize Psychiatry Northwest to:
(Print Patient/Legal Representative's Name)

☐ Release Records to **PLEASE ONLY CHECK ONE BOX** ☐ Obtain Records from

Name: _____

Address: _____

Phone: _____

Fax: _____

Purpose of request:

☐ Continuation of care ☐ Provider correspondence
☐ Insurance ☐ Other (Please Specify): _____

The information included in this authorization pertains to:

☐ Medication list only ☐ Medical information between dates
☐ The entire Medical Record _____ to _____
☐ Other: _____

Please check any of the appropriate boxes below for Specific Authorization

☐

Initial

* DRUG & ALCOHOL: I understand that my records may contain information, diagnosis or treatment for drug or alcohol abuse. I give my specific authorization for these records to be released (42 CFR 2.31).

☐

Initial

* STD/AIDS/HIV: I understand that my records may contain information regarding testing, diagnosis, or treatment of STD/AIDS/HIV. I give my specific authorization for these records to be released (RCW 70.24.105)

☐

Initial

* MINORS: A minor's patient signature is required in order to release information regarding conditions relating to the minor's reproductive care, sexually transmitted diseases (if age 14 and older), alcohol and/or drug abuse and mental health conditions (if age 13 and older).

I understand the following:

- I have a right to revoke this authorization in writing at any time, except to the extent that information has been released in reliance upon this authorization.
- This authorization is only valid for one year from the date it was signed and will automatically expire.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Signature of Patient or Legally Authorized Representative

Date

Print Name and Relationship of Legally Authorized Representative to the Patient