2366 Eastlake Ave E Suite 428 Seattle, WA 98102
Phone: (206)-402-3375 Fax: (206)-492-2020

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Patient Name: ______________________ Patient Date of Birth: ____________________

I ______________________ hereby authorize Psychiatry Northwest to:

(Patient/Legal Representative Name)

☐ Release Records to ☐ Exchange Records with ☐ Obtain Records from

Name: ____

Address: ____

Phone: ____

Fax: ____

The information included in this authorization pertains to:

☐ Entire Record ☐ Last Year of Records

☐ Other (Please Specify): ______________________________

Specific Authorizations

_______ (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 (CFR 42, Part 2).

_______ (Initial) **STD/AIDS/HIV:** I understand that my records contain information regarding testing, diagnosis, or treatment of STD/AIDS/HIV. I give my specific authorization for these records to be released (RCW70.24.105).

_______ (Initial) **MINORS:** A minor's patient's 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).

*By signing this page, I acknowledge that I have read and agree to the terms on this form. This authorization shall be in effect for 90 days after time of submission unless I revoke this authorization in writing. Any authorization requiring your signature that results in information disclosed to a non-covered entity may be subject to re-disclosure and no longer protected by federal or state law.

______________________________ ____________

Signature of Patient Date

______________________________ ____________

Signature of Legal Representative & Relationship Date