



2366 Eastlake Ave E Suite 428 Seattle, WA 98102

Phone: (206)-402-3375 Fax: (206)-493-2020

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

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).

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).

Release of Information Policy:

*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