

Authorization for Release of Health Care Information and Records

Patient Name _____ Date of Birth: _____
(First / MI / Last)

Information to be released FROM:	Information to be released TO:
<input type="checkbox"/> Eastside Family Health Center OR	<input type="checkbox"/> _____ (Organization / Person)
<input type="checkbox"/> _____ (Organization / Person)	_____ (Street Address)
_____ (Street Address)	_____ (City, State, Zip)
_____ (City, State, Zip)	_____ (Telephone / Fax #)
_____ (Telephone / Fax #)	<input type="checkbox"/> Eastside Family Health Center 11415 Slater Ave. Northeast, Suite 102 Kirkland WA 98033 Phone: (425) 899-2525 Fax: (425) 899-2526

Types of Information to be released:

I permit _____, (Provider name), herein referred to as "Provider," to release the following health care information to the Provider listed above. I understand that the Provider needs my written authorization to release any health care information about testing, diagnosis, procedures and/or treatment for alcohol and/or chemical dependency, reproductive health, sexually transmitted diseases (including HIV/AIDS) or psychiatric disorders/mental illness. Based on the box(es) I have checked below, the Provider may release all diagnostic, treatment information and records, except psychotherapy notes as defined by the Health Insurance Portability and Accountability Act of 1996, which requires a separate authorization.

- | | |
|---|---|
| <input type="checkbox"/> General Health Care | <input type="checkbox"/> Sexually Transmitted Diseases (HIV/AIDS) |
| <input type="checkbox"/> Alcohol and/or Chemical Dependency | <input type="checkbox"/> Psychiatric Disorders/Mental Illness |
| <input type="checkbox"/> Reproductive Health (including Abortion) | <input type="checkbox"/> Other: _____ |

Purpose for release and how information will be used:

- At the request of the individual
 For coordination of care
 Other: _____
 Other (please state specific date, specific time period, event or condition): _____

Timeframe of Release:

Unless I revoke it, this release will remain valid for ninety (90) days from the date of my signature below.

Signature: _____ Print Name: _____ Date: _____

If not the patient, I am the: Parent Legal Guardian Holder of Power of Attorney

If you are the legal guardian or holder of a power of attorney for the patient, attach legal documentation.

Revocation of Release:

I understand that I may change my mind and revoke this at any time. I will do this by letting the Provider know of my decision. Any change will be effective five (5) business days after the Provider receives my written notice. I understand that some or all of this information may already have been shared and the Provider will not be liable for any information already released.

Redisclosure:

Information disclosed as a result of this authorization may be redisclosed by the party listed above as the recipient, and may no longer be protected by state and federal privacy rules.

No conditions:

This authorization is voluntary. We will not condition your receipt of treatment on giving this authorization.

Please keep a copy of this release for your records.