2150 N 107TH Street, Suite 400/460 Seattle, WA 98133
Phone: (206) 402-3375 Fax: (206) 492-2020
Email: info@psychiatrynorthwest.com

AUTHORIZATION FOR THE RELEASE OF INFORMATION (45 CFR 164.508)

Patient Name: ______________________ Patient Date of Birth: ______________________

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

PLEASE ONLY CHECK **ONE** BOX

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

Name: ______________________

Address: ______________________

Phone: ______________________

Fax: ______________________

Purpose of request:

☐ Continuation of Care
☐ Insurance
☐ Provider Correspondence
☐ Other (Please Specify): ______________________

The information included in this authorization pertains to:

☐ Entire Record
☐ Medication List
☐ Other (Please Specify): ______________________
☐ Medical records between dates: ______ to ______
☐ Labs/Test Results

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 (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 (RCW70.24.105)

______ (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:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

______________________ ______________________
Signature of Patient or Legally Authorized Representative Date

____
Name and Relationship of Legally Authorized Representative to Patient