

Eastside Family Renewal Service



Authorization to Disclose Health and/or Mental Health Information

Client or
Patient Name: _____ DOB : _____

1. I authorize the use of disclosure of the above named individual's health and/or mental health information as described below.

2. The following individual or organization is authorized to make the disclosure:

Name: _____
Address: _____
Phone: _____
Fax: _____

3. The type and amount of information to be used or disclosed is as follows:
(Include information from last visit, last 12-months or exact dates where indicated)

Information from alcohol and/or drug and/or mental health records
(including dates of admission; diagnosis; medications and/or compliance; biopsychosocial evaluations; summary of treatment plans; progress, and compliance; discharge plan, date of discharge, and discharge status; urinalysis results; my compliance with recommended treatment, referrals, and continuing care).

Entire Record of medical history EXCEPT confidential HIV-related information
(include problem lists, medication list; allergies, immunizations; most recent history and physical, most recent discharge summary, laboratory results within the last 12 months; X-ray, MRI, PET or CAT Imaging Reports as they apply to any neurological or endocrine functioning or concerns; consultation reports)

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. **This information may be disclosed to and used by the following individual or organization: Nicole Laurent, LMHCA of Eastside Family Renewal Service, Office at Fern Life Center, 410 Newport Way NW, Suite B, Issaquah, Washington 98027**, for the purpose of assessment and appropriate care or assistance with objectives related to personal growth.

6. **I understand I have the right to revoke this authorization at any time.** I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to the information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the end of the pending of my claim or lawsuit if the sharing of information is occurring for the purpose of a personal injury claim or settlement.

7. **I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.** I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524 (HIPPA). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my medical and psychological caregivers responsible for the protecting of my private health and mental health information.

8. **You are further authorized to discuss my case in detail with Nicole Laurent, LMHCA, at Eastside Family Renewal Service, and assist her in any way she may request your services.**

9. I acknowledge receipt of a signed copy of this authorization _____ (Initials)

Signature of Client or Patient or Legal Representative

Date

If Signed by Legal Representative, Signature of Witness

Relationship to Patient

**A photocopy of this Authorization will be considered as an original.
This Release complies with the HIPAA Privacy Rules**

Please mail records securely to:

Eastside Family Renewal Service
Office at Fern Life Center
410 Newport Way NW, Suite B
Issaquah, WA 98027

For concerns regarding fax
transmittal please call 425.647-5775