Authorization to Release and Disclose Protected Health Information – Sensitive Information

Patient Information	Patient Name: _____ Date of Birth: _____ Address: _____ Alias/Nickname: _____ City: _____ State: _____ Zip: _____ Day Phone: _____
Clinic Health Care Provider (**Who** has the information you want released?) Please list the specific Provider and/or Clinic.	Clinic or Provider Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Fax#: _____ Day Phone:_____
Receiving Party (**Where** do you want the information sent?)	Name of Receiving Party: _____ Attention:_____ Address: _____ City: _____ State: ____ Zip: _____ Fax#: _____ Day Phone: _____
Authorization Content	I hereby authorize Community Health Center of Snohomish County and Recipient to discuss and disclose to each other specific Protected Health Information (PHI) as initialed below. I understand without this specific authorization, my PHI is protected from disclosure under the Health and Insurance Portability and Accountability Act (HIPAA), 45 CFR parts 160 and 164, and under 42 CFR part 2 protecting alcoholism and drug treatment records. I intend this authorization to include information concerning substance abuse services governed by RCW 70.96A, mental health services governed by RCW 71.05 or 71.24. The purpose of this disclosure is for evaluating my progress, treatment and coordinating my health care. I also understand that I may refuse to sign this authorization and my refusal will not result in denial of treatment.
Information Authorized for Release	Initial all Information you are authorizing to release: ____ Evaluation, Discharge & Treatment plans ____ Alcohol/Drug and Mental Health Assessments (progress) ____ Attendance (Compliance) ____ Urinalysis and other drug testing ____ Medications ____ Financial status to establish health insurance coverage ____ All Records (Continuity of Care) ____ Last Two Years of Records (All)
Release Instructions (**How** and **When** do you want the Information? **Who** do you want to pick up if not you and does CHC have valid documents on file?)	1. Release records by: a. ❑ Paper ❑ In person pickup ❑ Mail to receiving party ❑ Fax to receiving party ❑ Fax number: _____ b. ❑ CD/DVD ❑ In person pickup ❑ Mail to receiving party 2. Email is **not secure** and records will not be delivered in any other manner than above. 3. If in person pickup, the person picking up the records is the ❑ Patient ❑ Parent/Family/Friend ❑ Legal Representative (must have appropriate documents on file with CHC) 4. Name of person picking up records: _____ Relationship to patient: _____ 5. Verify identity of person picking up records: Driver's License, Costco Card or Bank Card with Photo ID.

1. **Authorization is valid for one year after date signed unless you enter a different date or expiration here: Date**: _____
2. I may remove this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it.
   I also understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal regulations.
3. A fee is charged for some copies of healthcare information and must be paid in advance.
4. **MINORS 13-17**: A minors signature is required in order to release information regarding the following conditions: Reproductive care such as contraception, pregnancy (any age), sexually transmitted diseases (14 years and older), alcohol/drug abuse (13 years and older), and mental health (13 years and older).
   I consent to releasing the protected health information.

_____ _____ _____

Patient/Guardian/Power of Attorney Signature **Authority to Sign on Behalf of Patient (Document Required)** **Date**

AUTHORIZATION TO REMOVE MY REQUEST for RELEASE OF INFORMATION: _____

Patient Signature Date