INFORMED CONSENT AND AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION (HIPAA COMPLIANT)

I, _____ DOB: _____ SSN (last four): _____, am requesting the designated agency listed below to release to me my confidential information/records. I also explicitly authorize the designated agency/agent to speak with the designated individual(s) regarding my confidential information.

Information to be released from:

_____
Name of Designated Agency, Individual or Provider

_____
Address

_____
Telephone Number Fax Number

Information pertaining to me or my confidential information may be released to:

Attorney:

_____
Attorney Name and/or Agency (and any agents, designees or representatives)

_____
Address

_____
Telephone Number Fax Number

_____
Email

Mitigation Specialist/Social Worker/Investigator/Expert:

_____
Investigator/Expert Name and/or Agency

_____
Address

_____
Telephone Number Fax Number

_____
Email

Information to be released and/or discussed:

- ☐ All of my health information and/or records maintained by the above-named institution/individual
- ☐ Evaluations, summaries of treatment and progress notes
- ☐ Psychological testing and/or psychiatric evaluation records
- ☐ Substance use records
- ☐ Educational records and/or transcripts
- ☐ Health information and/or records for the following date(s):
- ☐ Consult/communication/exchange of verbal information
- ☐ Other:

Patient/Client Authorization:

I authorize this release to extend to all aspects of testing, diagnosis or treatment. EXCLUDE the following information (initial):

_____ STD/HIV/AIDS _____ Substance Abuse _____ Psychiatric/Mental Health _____ Contraception/Prenatal Care

I understand that the above medical information may be subject to re-disclosure and may not be protected under state and federal laws protecting health care information unless protected by specific statutes protecting more sensitive information (e.g. 42 CFR Part 2 for alcohol and drug treatment records, Ch. 70.24 RCW for HIV/STD/AIDS information).

Refusal to sign this authorization will not affect the patient's ability to obtain health care services or reimbursement for services unless authorization is required to bill the patient's insurance company.

Disclosure of this information is at my request.

I may revoke this authorization in writing at any time, except to the extent that action has already been taken. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released.

Unless cancelled earlier by me, this authorization will expire **two years** from the signature date or on _____.

A copy or fax shall be considered valid in lieu of the original.

Signature: _____ Date: _____
(Patient/Client, Guardian or Authorized Representative)

Witness: _____ Date: _____