COUNSELING SERVICES FOR WELLBEING

Office Location:
15811 Ambaum Blvd. SW Suite 110
Burien, WA 98166
Phone: 206-242-8211
Fax: 206-242-0162
info@buriencenterforhealthandwellbeing.com
www.buriencenterforhealthandwellbeing.com

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ **DOB:** _____

The person named above hereby authorizes _____(requesting provider) to:
□Request Health Information from □ Discuss Information with □ Send Information to

The person named above authorizes information to be requested or released by representatives of:
Name of Provider or Facility: _____

Address: _____

Fax: _____ Phone: _____

Specific Health Information Authorized:
□ I authorize disclosure of all my health information, including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; or

□ I authorize only the disclosure of the following information:

_____

Specific Health Information Requested (Requesting Provider to fill out): □ Entire Record / OR the following:

Medication List □
Laboratory results from past 12 months □
Last Visit Summary (Incl. Current Meds & Dx) □
Discharge Summary □
Psychological/ Neuropsychological Testing □
Individual Educational Plan (IEP) □
Last Physical Exam □
Diagnostic Test Results (ECG, MRI, CT, Sleep Study, EEG) □
Past Psychiatric Evaluation □
Emergency Room Visit Summary □
□ Other: _____
_____

I understand and agree that:

- This authorization is voluntary;
- My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider, except to the extent that the information being requested may assist your health care provider in determining appropriate treatment.
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- This authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying my provider in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Authorization:
Signature of Patient or Authorized Representative: _____

Date: _____ Relationship if not Patient: _____