BURIEN CENTER
For Health and Wellbeing

Collaboratively Caring for the Mind, Body and Soul

Authorization for Release of Health Information

Patient Name:_____**Date of Birth:**_____

I voluntarily authorize and direct my **health care provider** (where the health information is coming **from**) _____ to use or disclose my health information to the recipient that I have identified below.

Recipient: Name of person or class of persons to whom my health care provider may disclose my health information (where the information is being shared **to**):

_____.

Address of the recipient or where my health information should be delivered if hard copy (may also be faxed):

_____

Purpose: I understand that the specific purpose of this Authorization is:

_____

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: This authorization permits the above provider to disclose the following medical records:
__All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

__All of my health information described above except for the following:
_____

__Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)_____

Term: This Authorization will remain in effect for one year from the date of this disclosure **OR**:
__From the date of this Authorization until the _____ day of _____, 20__.

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: 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.

Revocation:I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____

Signature Date Name and relationship if not the client/ patient