



10200 NE 132nd Street, Kirkland, WA 98034
Telephone: (425) 821-2000 x1569 Fax: (425) 458-1708

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL PATIENT HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_
Patient's Telephone: (\_\_\_\_\_) \_\_\_\_\_

I authorize Fairfax Behavioral Health to release information to:
Organization/Individual: \_\_\_\_\_ Attn: \_\_\_\_\_
Street Address: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Format of the information to be released: [ ] Paper Copies [ ] Compact Disc (CD) [ ] Secure Email
If you wish for the recipient to receive your health information electronically on a CD or secure email, please provide an email address.

Recipient's Email: \_\_\_\_\_

Information to be released to Organization/Individual:

Requesting records from dates \_\_\_\_\_ to \_\_\_\_\_
Month/Year Month/Year

- [ ] Discharge Summary [ ] Psychiatric Evaluation
[ ] Transition of Care Packet [ ] Other (Specify) \_\_\_\_\_

Purpose of Release:

- [ ] Continuing Care [ ] Copies for Own use
[ ] Legal [ ] Other (Specify) \_\_\_\_\_

Release Requiring Specific Consent:

- [ ] Sexually Transmitted Diseases (Including HIV/AIDS) [ ] Mental Health/Illness
[ ] Drug/Alcohol or other substance abuse

Minors: A minor patient's signature is required to release the following information: 1) Conditions relating to reproductive care (age 14 and older), 2) mental health conditions (age 13 and older), and 3) Drug and Alcohol or other substance abuse diagnosis or treatment (age 13 and older). (Subject to Federal Regulation 42 CFR Part 2 and HIPAA 45 CFR Parts 160 & 164)

Signature Required for Release of Information:

I understand that:

- Authorizing the disclosure of my health information is voluntary. I do not need to sign this form in order to assure treatment or payment.
• I can revoke this authorization at any time by contacting the Health Information Management Department, address and phone number noted above. I understand that once the information has been released, the information cannot be recalled.
• I understand that information used or disclosed in accordance with this authorization may no longer be protected by Federal law, and could be used or re-disclosed by the receiving party.
• This authorization will expire 120 days from the date signed below unless another otherwise specified \_\_\_\_\_.
• By signing below I am agreeing that my protected health information may be released to the organization/individual listed on this authorization.

\_\_\_\_\_  
Patient or Personal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name