Behavioral Health Release of Medical Information Instructions

A release of information provides specific access to protected health information to an individual or entity that is authorized. It specifies who the information is to be released to and how long the information is to be released. We will do everything in our ability to protect your information. However, it is important to understand by completing the form there is risk that information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

1. **Patient Information**
   Information is for the person whose records are being requested. Name and date of birth are required. Parent/Guardian information should be included as well as the relationship to the patient.

2. **Information to be Released BY**
   This is the Organization or Person who is releasing the information, and must include a specific and complete address, phone number and/or fax number written down in order for the release to be processed.

3. **Information to be Released TO**
   This the Organization or Person that will be receiving client information, and must include a specific and complete address, phone number and/or fax number written down in order for the release to be processed.

4. **Type of Medical Information Requested**
   Please initial the box that applies to the type of information that is being released. If the type is not listed, please indicate what is to be released, being specific as possible.

5. **Reason for Request**
   Indicate the reason for releasing the information. If the reason is not listed, please specify.

6. **Expiration of Release of Information**
   Indicate the length of time this authorization is valid listing a date or specific event.

7. **Signature(s)**
   All requests must be signed and dated. Parent/guardians must sign and date this form for minors under the age of 14. Please note that if the child is under 14, and both parents have legal custody, a Records Request and Release of Information is required from both parents before a Records Request can be processed.

INTERNAL USE ONLY	Received By: __________	On: __________	Processed By: _________	On: _________

Behavioral Health Release of Medical Information

Please read all information and instructions before completing and signing the authorization form.

Patient Name: ____ DOB: ____________________

Parent/Legal Guardian Name (if applicable): _____________ Relationship to patient: _______________

INFORMATION TO BE RELEASED **BY:**	INFORMATION TO BE RELEASED **TO:**
REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER ____ Organization/Person Name ____ Street Address ____ Phone Fax	**REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER** ____ Organization/Person Name ____ Street Address ____ Phone Fax

TYPE OF MEDICAL INFORMATION REQUESTED (Please Initial)**:**

- ☐ Billing, Eligibility, Benefit Coverage
- ☐ Appointments &/or Scheduling
- ☐ My health information related only to the following treatment or condition: ________________________
- ☐ My health information only for the following date(s): ____
- ☐ My health records related to drug/alcohol/substance (EXCLUDING progress notes)
- ☐ My health records related to drug/alcohol/substance (**INCLUDING** progress notes)
- ☐ My health records related to emotional/mental/developmental disabilities/psychiatric conditions (EXCLUDING progress notes)
- ☐ My health records related to emotional/mental/developmental disabilities/psychiatric conditions (**INCLUDING** progress notes)
- ☐ Other: ____

REASON FOR REQUEST: ☐ Personal ☐ Transfer of Care ☐ Disability ☐ Insurance ☐ Legal ☐ Continuing Care ☐ Other (please explain): ______________

AUTHORIZATION: I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above-named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility benefits).

MINORS AGE 14-17: A minors patient's signature is required in order to release information related to the following information: (1) conditions relating to the minors reproductive care including, but not limited to: contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 14 and older), and (3) mental health conditions (age 14 and older).

This authorization expires _________(date or event). Authorization will expires 1 year from date signed, if not otherwise specified.

Patient signature ____ Date ________________

Parent/Legal Guardian ______________________________________ Date ________________

Relationship to patient, if other than patient ____

Federal and state laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains. A general release is NOT sufficient. 42 CFR Part 2:RCW 70.02.300

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