

Health Alternatives, LLC

1015 4th Ave. W, Suite A/B
Olympia, WA 98502

AUTHORIZATION TO DISCLOSE INFORMATION

I hereby authorize:

Name of Facility/Person: _____
Street Address: _____
City/State/Zip: _____
Phone Number: _____

to disclose the following information verbal/written to (see checklist) to:

Name of Facility/Person _____
Street Address: _____
City/State/Zip: _____
Phone Number: _____

in regard to _____ date of birth _____

Social Security Number of Client _____

The above information is released for only the following purpose. Other use of this information is prohibited.

Reason for Disclosure _____

PLEASE READ CAREFULLY:

- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so *in writing* and present my written revocation to staff of Health Alternatives, LLC. I further understand that actions already taken based on this authorization, prior to my revocation, will be affected by this revocation.
- I understand that my medical information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may contain information relating to sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases, and/or drug and alcohol abuse.
- I understand that I have the right to receive a copy of this authorization. Request Copy? ____ YES ____ NO
- I understand that authorizing the disclosure of my medical and/or health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical records, I can contact the health Privacy Officer for this covered entity.

This authorization (unless revoked earlier) expires one year from below signature date.

Signature of Patient

Date

Signature of parent, guardian, or legal representative

Date

Signature of Authorized Representative
Or Witness if Signature is by Thumbprint or Mark

Date

Information to be Disclosed

- Progress Notes
from _____ to _____
 - Initial Assessment
 - Treatment Plan
 - Psychological Evaluation
 - Discharge Summary
 - Entire Chart – subpoena only
 - Treatment required, Diagnosis, and Pertinent Information
 - Letter Dictated
 - Billing information/appointments
 - Other (Please specify)
- _____
