AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Associated Behavioral Health Care - 1800 112th Ave NE Ste.150W Bellevue, WA 98004
Phone: (425) 646-7279 Fax (425) 671-6198

1. PATIENT INFORMATION

Patient Name _____ **Date of Birth** _____

Phone Number: _____

2. INFORMATION TO BE RELEASED FROM (SELECT ONE ONLY)

☐ **Associated Behavioral Health Care**
☐ **Organization or Person**_____

Address _____ **City, State, Zip** _____

Phone _____ **Fax** _____

3. INFORMATION TO BE RELEASED TO (SELECT ONE ONLY)

☐ **Associated Behavioral Health Care**
☐ **Organization or Person** _____

Address _____ **City, State, Zip** _____

Phone _____ **Fax** _____

4. PURPOSE OF RELEASE

☐ **Personal**
☐ **Legal**
☐ **Continuity of Care**
☐ **Other (Specify below)**

_____
_____

5. INFROMATION TO BE RELEASED

☐ **Information required to complete and transmit an assessment**
☐ **Program compliance and completion of treatment**
☐ **Substance Abuse records**
☐ **Mental Health/Psychiatric records**
☐ **Financial information**
☐ **Lab test dates and results**
☐ **Other** _____

6. EXPIRATION (No longer than reasonably necessary to serve the purpose of this consent)

☐ **At completion of treatment**
☐ **90 Days after completion of court proceedings or after discharge from treatment, whichever is later**
☐ **1 year from execution of this document**
☐ **Other** _____

7. MY RIGHTS/MY AUTHORIZATION

I understand that my treatment records are protected under the Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR, parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in regulations.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

By signing below, I allow ABHC to disclose information via US mail, FAX, phone and email. I have been provided a copy of this form.

8. SIGNATURE

_____ _____

Signature of Patient or Legally Responsible Party **Date**

Prohibition on Redisclosure of Confidential Information

If this notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.