**Consent Authorization For Release of Information**

I, ( client name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize (name of agency)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_

(Provider/Facility/ or other)

to release information of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Four of Social Security#:** \_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth:** \_\_\_\_\_\_\_\_\_\_

**(Patient’s Name)**

The record is to be given to BIMA Believing In Myself Again

Contact Person/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office# 206-393-2273 email: Bridgette@Bimaservices.org

**I authorize the records/information to be given in the following ways:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Written/Photocopy/Paper | * Electronic Format | * Fax | * Electronic Mail \* | * Verbal |

**Why is the record or information being released?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dates of Healthcare or Treatment: N/A** From: \_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What information or part of the health record may be given?**

|  |  |  |
| --- | --- | --- |
| * Progress Notes * Discharge Summary * Housing information | * Laboratory Reports   + Consultation Reports * Records from other facilities | * + Operative Reports |
| * Other (Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**I give specific authorization to give the following information:**

|  |  |
| --- | --- |
| * HIV test results/Documentation of AIDS diagnosis * Sexually Transmitted Disease test results * Drug and alcohol abuse treatment records/information | * Psychosocial information or assessment * Psychiatric/Mental Health treatment records/information |

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Concerto Medical Center in writing.

I understand that my records may contain information regarding mental health, diagnosis and treatment, drug and alcohol abuse which is protected (per 42CFR, Part 2), the testing diagnosis, or treatment of HIV/AIDS and or sexually transmitted diseases (Per RCW 70.24.105). I give specific authorization for these protected records to be released

Unless revoked earlier, this authorization expires in one year unless I specify another time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I release BIMA named in this authorization from legal responsibility or liability for the release of the health record as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

**X\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient (or Patient Representative)** **Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name of Patient or Patient Representative**  Authority of Representative to Act for Patient

(Relationship to Patient)

\* Need to ensure separate E-mail Authorization Agreement is signed.

Note: Release of Psychotherapy notes requires a separate authorization.