EXAMPLE AUTHORIZATION FOR DISCLOSURE/RELEASE OF INFORMATION FOR PROTECTED HEALTH INFORMATION

AUTHORIZATION TO DISLOSE RECORDS OF:

Name–(last, first middle)			Date of birth
(The following information may help in locating records)	Former names		
Client identification number	Other identification number	Dates of service	Location of service

DISCLOSE TO:

Name–(last, first middle)		Title
Organization or business name (if applicable)		
Address (street, city, state zip code)		
Phone (include area code)	Fax (include area code)	E-mail address
Reason for disclosure		
Authorization:		

RECORDS TO BE DISCLOSED:

I authorize the following records to be disclosed:

☐ Health or treatment related records described as follows: **If checked, a separate form must be used for release of all other information. Parent signature not required for 13 or older seeking treatment on their own.**

☐ Educational/School records excluding Health or Treatment Records (If the student is not 18, a parent, legal guardian or Custodian must sign this release as follows: (by date, type of record, etc.)

☐ Other confidential information except health, mental health or treatment information (may be limited by date or type of record):

SPECIAL RECORDS:

If client records include information regarding HIV/AIDS, STDs, Mental Health, Alcohol or Chemical Dependency treatment, you must complete this section to allow disclosure of these records.

I give my permission to disclose the following records (check all that apply):

☐ HIV/AIDS and STD test results, diagnosis or treatment records (RCW 70.24.105)

☐ Mental health records (RCW 71.05.620), including:

☐ Alcohol or Chemical Dependency (CD) records (42 CFR Part 2), including:

- This consent is valid for ☐ 90 days OR ☐ until _____ (date or event).
- I may revoke or withdraw my permission in writing at any time. Information already disclosed or required by court order will not be affected.
- I understand that my records may no longer be protected under the laws that apply to the releasing agency after this disclosure.
- A copy of this form is valid to give my permission to disclose records. Agencies may charge to provide copies of records.
- ***Refusal to sign this form may not be a basis to deny any service***.

AUTHORIZED BY:

Signature	Date	Telephone number (include area code)
Print name	Witness/notary (sign and print name, if applicable)	

If I am not the person who is the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

☐ Parent of minor ☐ Legal Guardian ☐ Personal representative ☐ Other:

NOTICE TO THOSE RECEIVING INFORMATION:

If these records contain educational records, information about HIV, STDs, alcohol or drug abuse, or protected health information, ***you may not further disclose this information under federal and state law without specific permission of the subject and meeting specific legal requirements.***