

**AUTHORIZATION TO RELEASE INFORMATION**

Consumer's Name

DOB

**I Authorize Comprehensive Healthcare to:**

- Send Information to:**     **Obtain Information from:**     **Exchange Information With:**

Agency/Person: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code : \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_ (for sending encrypted emails only)

**For the purpose of:**    Care Coordination     Benefits     Legal     Personal

Other (specify) \_\_\_\_\_

**This request and authorization applies to (check item[s] that apply):**

**Mental Health Treatment and/or**    **Substance Use Disorder Treatment**

- |  |  |
|--|--|
| <input type="checkbox"/> All Mental Health Records | <input type="checkbox"/> All Substance Use Records             |
| <input type="checkbox"/> Intake Assessment (s)     | <input type="checkbox"/> SUD Assessment                        |
| <input type="checkbox"/> Psychiatric Evaluation    | <input type="checkbox"/> Compliance and Non Compliance Reports |
| <input type="checkbox"/> Physician Notes           | <input type="checkbox"/> Discharge Summaries                   |
| <input type="checkbox"/> Therapist Notes           | <input type="checkbox"/> UA test results                       |
| <input type="checkbox"/> Treatment Plans           | <input type="checkbox"/> TB test results                       |
| <input type="checkbox"/> Other _____               | <input type="checkbox"/> Labs                                  |

Would you like to receive the information on:    Paper    CD or    E-mail

**This authorization will expire 1 year from date signed.**

If this authorization is to a financial institution or my employer for purposes other than payment, then the authorization will expire one year after signing.

**Send all authorizations by mail or fax to:**

COMPREHENSIVE HEALTHCARE, P.O. Box 959, Yakima, WA 98907

fax (509) 575-4234.

phone (509) 575-4084

I understand that my records are protected under federal and/or state law and cannot be disclosed without my written consent unless otherwise provided for in the regulations (42 C.F.R. Part 2 [if I am receiving Substance Use Disorder treatment services]). I also understand that my written consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, and alcohol or other drug use unless otherwise provided for in the regulations. If I have been tested, diagnosed or treated for HIV/AIDS, sexually transmitted disease, psychiatric disorders/mental health, and/or alcohol or other drug use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment as indicated above. I understand that once the above information is disclosed, it may be re-disclosed by the recipient (except when prohibited) and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. 42 CFR part 2 prohibits unauthorized disclosure of these records. I understand that I do not have to sign this authorization in order to receive health care benefits (treatment, payment, enrollment, or eligibility for benefits) except for health care services necessary to create any assessment or report for disclosure to the recipient identified in this authorization. **This authorization may be revoked at any time by notifying the Health Information Management Department, P.O. Box 959, Yakima, WA 98907 in writing, except to the extent that action has already been taken in reliance on it.** Comprehensive Healthcare may charge a reasonable fee for duplicating records (RCW 70.02.010).

If the consumer is 12 years of age or younger this release must be signed by the consumer's parent. Consumers 13 years of age or older must sign this release for it to be valid.

**By signing below, I acknowledge that I have read and agree to the terms on both sides of this form. The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.**

\_\_\_\_\_  
Consumer's Signature or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by person other than consumer, print name, provide relationship and description of authority

\_\_\_\_\_  
Print Consumer's Name

\_\_\_\_\_  
DOB

**INTERNAL ACTION REQUIRED:**     Request Records     Send Records     File Release in Chart  
 Copy given to Consumer     Copy Refused by Consumer