Comprehensive HEALTHCARE

AUTHORIZATION TO RELEASE INFORMATION

_____ _____
Consumer's Name DOB

I Authorize Comprehensive Healthcare to 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**

☐ All Mental Health Records
☐ Intake Assessment (s)
☐ Psychiatric Evaluation
☐ Physician Notes
☐ Therapist Notes
☐ Treatment Plans
☐ Other _____

☐ All Substance Use Records
☐ SUD Assessment
☐ Compliance and Non Compliance Reports
☐ Discharge Summaries
☐ UA test results
☐ TB test results
☐ Labs

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

This authorization will expire 1 year from date signed.

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.

_____ _____

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

Staff Assisting with Authorization form:_____