Comprehensive HEALTHCARE

AUTHORIZATION TO RELEASE INFORMATION

Client'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)

All records will be transmitted electronically to the email provided above, unless one is not provided, or unless an alternative method is selected: *Preferred alternative(optional)*: ☐ Paper ☐ CD ☐ Fax

The information exchange is for the purpose of:
☐ Coordination of Care ☐ Benefits ☐ Legal ☐ Personal ☐ Other: ________________

This authorization applies to the following types of records (check all items that apply):

☐ **All mental health, substance use disorder and/or medical treatment records** *(or specify below):*

Mental Health Treatment Records:

☐ All Mental Health Records (or specify below)

- ☐ Intake Assessment(s)
- ☐ Psychiatric Evaluation
- ☐ Physician Notes
- ☐ Treatment Progress Notes
- ☐ Treatment Plan(s)
- ☐ Lab Results
- ☐ Urine Analysis/Urine Drug Screen Results
- ☐ Compliance Report(s)
- ☐ Discharge Summary
- ☐ Other ________________

Substance Use Disorder Treatment Records:

☐ All Substance Use Records (or specify below)

- ☐ SUD Assessment(s)
- ☐ Physician Notes
- ☐ Treatment Progress Notes
- ☐ Treatment Plan(s)
- ☐ TB Test Results
- ☐ Urine Analysis/Urine Drug Screen Results
- ☐ Lab Results
- ☐ Compliance Report(s)
- ☐ Discharge Summary
- ☐ Other ________________

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. Comprehensive Healthcare may charge a reasonable fee for duplicating records (RCW 70.02.010).

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.

This authorization will expire one (1) year from date signed. By signing below, I acknowledge that I have read and agree to the terms on both sides of this form.

Signature of Client (If 13 years of age or older, signature must be present for release for release to be valid. If 12 years of age or younger, only printed name and date of birth are required).

Print Client Name: ______________________________ ____________ ____________

Date of Birth Date

Client's Signature: ______________________________

Parent or Guardian signature required if client is 12 years of age or younger (include printed name and relationship to the client, e.g., parent, legal guardian, etc.)

Print Name: ______________________________ ____________ ____________

Relationship Date

Signature: ______________________________

Please send all authorizations or information by mail, fax, or email to:

Mail:	Fax:	Email:
Comprehensive Healthcare P.O. Box 959, Yakima, WA 98907	(509) 575-4234	HIMemail@comphc.org

If you have questions, please call the Health Information Management department at (509) 576-4340.

For Internal Use Only:

Copy of Release:	☐ Provided to Client	☐ Declined by Client	
Medication Management Only Referral:	☐ Medical Provider	☐ Therapist	
HIM Action Requested:	☐ Request Records	☐ Send Records	☐ File Release in Chart