

# Puget Sound Psychiatric Center

10634 E Riverside Drive

Suite 130

Bothell, WA. 98011

Tel: (425) 806 5021

Fax: (425) 486 3949

## AUTHORIZATION FOR RELEASE OF INFORMATION: TO RECEIVE, USE OR RELEASE PROTECTED HEALTH INFORMATION

(Name of Patient)	(Date of Birth)
(Address)	(Signature of Patient or Legally Authorized Representative/ Guardian)

I, ( the Patient or Legally Authorized Representative/ Guardian) hereby authorize  
**PUGET SOUND PSYCHIATRIC CENTER**  
to

<input type="checkbox"/> <b>RECEIVE FROM:</b> (Name of Individual/Agency)	<input type="checkbox"/> <b>TO RELEASE TO</b>	(Address)
(Fax)		(Telephone)

I understand that this authorization extends to the following **CONFIDENTIAL** information/ records;

- Medical  Psychiatric  Intake/Discharge Note  Chemical Dependency  Psych Testing  Therapy Notes  Lab Tests  
 Other Clinically Relevant Records, including \_\_\_\_\_

**Purpose:** To aid in the success of treatment and/or to provide continuity of care

- Information to Use or Release:**  Talk with the provider  
 Release all relevant health care information in my medical record.

*If the ROI is addressed to a school/educator, I understand that the purpose of this request is to assist in planning an appropriate educational program for my child and that no other party except authorized school personnel shall have access to this information.*

**Please FAX/ MAIL/SEND  
All relevant information at your earliest convenience  
TO  
THE ADDRESS/ FAX LISTED ABOVE**

The material in this facsimile/ letter is intended for the use of the individual to whom it is addressed and may contain information that is confidential, privileged and exempt from disclosure under applicable law. If you are not the intended, be advised that the unauthorized use, disclosure, copying, distribution or the taking of any action in reliance on this information is strictly prohibited. If you have received this facsimile in error, please notify us immediately at the phone number listed below.

### HIPAA Compliance

**Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to coordinate health care, to seek insurance payment or to perform other specific health care procedures/services consented to by the patient.**

- I understand that I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form:
  - To receive health care when the purpose is to create health care information for a third party.
- I understand that if I revoke this authorization, it would not affect any actions already taken by the Puget Sound Psychiatric Center based upon this authorization, prior to it being revoked.
- This authorization expires in  90 days;  180 days;  End of Treatment; or  by \_\_\_\_\_.
- I understand that I can revoke this authorization at any time in writing.

Signature (Patient/Guradian or Legally authorized Representative)	Date
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