PUGET SOUND BEHAVIORAL MEDICINE

Authorization to Release Health Care Information

Patient's name:____ Date of birth:_____________

Contact person: _______________________________ Phone number: ____________________

I request and authorize ____________________________________ to release health care information of the patient named above to:

Name: ____

Address: ____

City, State:___________________________________ Zip code:______________

Institutional Affiliation: ____

This request and authorization applies to:

________ Health care information relating to the following treatment, condition, or dates of treatment:

____

________ All health care information

________ Other:____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

*** *If photocopied records are requested from Puget Sound Behavioral Medicine, a prepaid $20 copying fee applies.* ***

This authorization expires on _____________________

____

Signature of patient or patient's authorized representative Date signed

____

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

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