

SALVEO COUNSELING CENTER

17130 Avondale Way NE Suite 114
Redmond, Washington 98052

Telephone: 425-868-5777

AUTHORIZATION TO DISCLOSE/ REQUEST TO ACCESS PROTECTED HEALTH INFORMATION

Patient Name: _____
Previous Name if Applicable _____

Date of Birth: _____
Daytime Phone Number _____

THIS FORM AUTHORIZES THAT THE INFORMATION SPECIFIED BELOW REGARDING THE PATIENT STATED ABOVE BE SHARED BETWEEN:

Salveo Counseling Center
17130 Avondale Way NE
Suite 114
Redmond, WA 98052
P: 425 868 5777
Fax: 425 440 3976

AND

Name: _____
Address: _____

Phone: _____
Fax: _____

TYPE OF INFORMATION TO BE DISCLOSED:

- All private healthcare information necessary for the purpose of coordination of my healthcare.
- All medical records (all records archived per Washington State Records Retention Guidelines).
- Other

PURPOSE OF DISCLOSURE / EXCHANGE OF INFORMATION:

- AT PATIENT'S REQUEST SPECIALIST TRANSFER OF CARE COORDINATE TREATMENT

RELEASE REQUIRING SPECIFIC CONSENT:

I am aware that my records may contain healthcare information relating to testing, diagnosis, or treatment for HIV/AIDS, for any other STD, for chemical dependency, and/or for mental health. I specifically authorize _____ to disclose any and all such information, if not excluded by initialing below:

I intend to exclude from this authorization for healthcare information relating to testing, diagnosis or treatment for the following: Chemical Dependency; Mental Health; HIV/AIDS; Sexually Transmitted Infections

REVOCATION/ RE-DISCLOSURE: I understand that I may revoke this authorization at any time by giving my health care clinician a written and signed statement of revocation, and that such revocation will not be effective to the extent that substantial action may have already been taken in reliance on the authorization, including provision of health care services requiring subsequent disclosure to effect payment. I also understand that unauthorized re-disclosure of my health information by the recipient is a potential risk. If re-disclosed privacy laws may no longer protect the information.

YOUR SIGNATURE BELOW CONFIRMS THAT YOU UNDERSTAND AND AGREE TO THE TERMS OUTLINED AND HEREBY RELEASE _____ FROM ALL LEGAL RESPONSIBILITY THAT MAY ARISE FROM THE RELEASE OF INFORMATION.

SIGNATURE OF PATIENT/ REPRESENTATIVE
(age 13 and above)

SIGNATURE OF PATIENT/ REPRESENTATIVE
(age 13 and below)

RELEASE OF INFORMATION EXPIRES 90 DAYS FROM TODAY'S DATE: _____

PARENTAL REQUEST FOR CHILD'S MEDICAL RECORDS: I hereby declare under penalty of perjury, that I am the natural or adoptive parent or legal guardian of said child and there is no court order restricting or prohibiting my access to such medical records.

PARENT OR LEGAL GUARDIAN _____ DATE _____