10200 NE 132nd Street, Kirkland, WA 98034
Telephone: (425) 821-2000 x1569 Fax: (425) 820-3533

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth: ___/____/_____
Patient's Telephone: (_____) _____

I authorize Fairfax Behavioral Health to release information to:
Organization/Individual: _____ Attn: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: (_____) _____ Fax: (_____) _____

Format of the information to be released: ☐Paper Copies ☐Compact Disc (CD)
If you wish for the recipient to receive your health information electronically on a CD, please provide an email.
Recipient's Email: _____

Information to be released to Organization/Individual:

Requesting records from dates _____ to _____
Month/Year Month/Year

☐Discharge Summary ☐Psychiatric Evaluation
☐Transition of Care Packet ☐Other (Specify) _____

Purpose of Release:

☐Continuing Care ☐Copies for Own use
☐Legal ☐Other (Specify) _____

Release Requiring Specific Consent:

☐Sexually Transmitted Diseases (Including HIV/AIDS) ☐Mental Health/Illness
☐Drug/Alcohol or other substance abuse

Minors: A minor patient's signature is required to release the following information: 1) Conditions relating to reproductive care (age 14 and older), 2) mental health conditions (age 13 and older), and 3) Drug and Alcohol or other substance abuse diagnosis or treatment (age 13 and older). (Subject to Federal Regulation 42 CFR Part 2 and HIPAA 45 CFR Parts 160 & 164)

Signature Required for Release of Information:

I understand that:

- Authorizing the disclosure of my health information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can revoke this authorization at any time by contacting the Health Information Management Department, address and phone number noted above. I understand that once the information has been released, the information cannot be recalled.
- I understand that information used or disclosed in accordance with this authorization may no longer be protected by Federal law, and could be used or re-disclosed by the receiving party.
- This authorization will expire 120 days from the date signed below unless another otherwise specified_____.
- By signing below I am agreeing that my protected health information may be released to the organization/individual listed on this authorization.

_____ _____
Patient or Personal Representative Signature Date

_____
Printed Name