Valley|Cities

REQUEST FOR THE RELEASE OF HIPAA PROTECTED HEALTH INFORMATION

AUTHORIZATION FOR USE AND DISCLOSURE OF HIPAA PHI

Return to: MEDICAL RECORDS
33405 8TH Ave S, Suite 200
Federal Way, WA 98003

☏ (206) 408-5227
FAX (253) 835-9976

CLIENT'S FULL LEGAL NAME _____ CLIENT'S DATE OF BIRTH _____

CLIENT'S SOCIAL SECURITY NUMBER - IF AVAILABLE _____ CLIENT'S PHONE NUMBER _____

I HEREBY REQUEST VALLEY CITIES TO RELEASE MY RECORDS TO:

The following person or organization:

NAME OF PERSON OR ORGANIZATION _____ RELATIONSHIP TO CLIENT _____ PERSON OR ORGANIZATION'S PHONE / FAX # _____ / _____

PERSON OR ORGANIZATION'S FULL ADDRESS _____

Date Range to be included: **FROM:** _____ **TO:** _____

Types of Records: ☐ All HIPAA Records ☐ All Financial/Billing Records

Or only items checked:

- ☐ Assessment(s), Update(s)
- ☐ Crisis Plan
- ☑ Treatment Plan(s)
- ☐ Scheduling/Appointment History
- ☐ Discharge Summary(ies)
- ☐ Psychiatric Evaluation
- ☐ Psychiatric or Medical Notes
- ☐ Active Medications
- ☐ Active Problem List (Diagnoses)
- ☐ Laboratory Reports/Results
- ☐ Individual Treatment
- ☐ Group Treatment
- ☐ Family Treatment
- ☐ Peer Services
- ☐ Case Management/Community Support
- ☐ Other (specify): _____

Additional Requests for Specific Sensitive Information Types

- ☑ I request the release of mental health treatment information (required for mental health outpatient programs)
- ☐ I request the release of information about sexually transmitted diseases
- ☐ I request the release of information about HIV or AIDS diagnoses or treatment
- ☐ I request the release of ***verbal information*** about my treatment

Additional Request for Information to be OBTAINED from the Above Named Person or Organization

☐ I authorize the above named person or organization to ***send the records*** listed below Valley Cities in order to coordinate my care and treatment services (Describe as detailed as possible):_____

_____

Expiration *Unless otherwise specified, this ROI will automatically expire on the date of discharge.

- ☐ Upon my discharge from Valley Cities services
- ☐ Upon one-time receipt or release of the above information
- ☐ On this date: _____

I understand that:

- Only the person who has consented for care (including minors 13 years of age and older) can authorize for release of records. (RCW 70.02.130 and RCW 71.34.530). Any person who is a legal representative or durable power of attorney for the client must provide legal documentation (RCW 7.70.068).
- Any records that contain information regarding mental health are protected by state law (RCW 70.02); drug/alcohol abuse or treatment records are protected under federal confidentiality laws (42 CFR 2); HIV/AIDS or confirmed STD tests or treatment records are protected by state confidentiality laws (RCW 70.24).
- I may cancel this authorization at any time, except to the extent that action has already been taken. To revoke authorization to release Protected Health information, I must do so in writing.
- I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).
- It is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

CLIENT SIGNATURE _____ RELATIONSHIP TO CLIENT _____

WRITTEN NAME _____ EFFECTIVE DATE FOR RELEASE _____

AUTHORIZED SIGNATURE IF NOT *SELF/CLIENT _____

Valley Cities ID# _____