Authorization for Release of Health Information
Including Alcohol/Drug Treatment and Mental Health Information and
Confidential HIV/AIDS-Related Information

Psychology Clinic
Washington State University
P.O. Box 644820
Pullman, WA 99164-4820
(509) 335-3587 Fax: (509) 335-1030

Client Name:					
Last:	First:		Middle:		
Street Address	City	State	Zip	Phone	Date of Birth

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form in accordance with RCW 70.02.030. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 10. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 10, I specifically authorize release of such information to the person or entity indicated in Item 7.
2. With some exceptions, health information once disclosed may be redisclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 6. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure.
5. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

6. Name and address of provider or entity authorized to release this information:

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7. Name and address of person, provider, or entity to whom this information will be disclosed:

8. This information is released for the purpose of: ☐ Coordination of Services ☐ Evaluation
☐ Treatment Planning ☐ Billing ☐ Other: _____

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9. Unless revoked earlier by me, this authorization will expire 90 days after the date this document is signed.

☐ **This authorization permits the release of <u>all</u> information in my medical record**

☐ **This authorization <u>limits</u> release to the following information** (check all that apply):

- ☐ Drug and alcohol treatment records and related information, including: ☐ Evaluation results ☐ Group Notes ☐ Treatment Recommendations ☐ Discharge Summary
- ☐ Medication utilized and related information
- ☐ Full disclosure of information relating to my HIV/AIDS status
- ☐ Information about how my condition affects or has affected my ability to complete tasks and activities of daily living and/or my ability to work
- ☐ Progress notes
- ☐ Psychological evaluation, including: test results, summaries, and reviews
- ☐ Assessment reports
- ☐ Educational records
- ☐ Other (Specify): _____

10. **For the following information to be released, please indicate the information to be disclosed <u>and initial</u> below:**

Information to be Disclosed	**Client's Initials** (if 13 or older)	**Parent/Guardian/Authorized Adult's Initials** (if client is under 18)
☐ Records from alcohol/drug treatment programs		
☐ Mental health treatment records		
☐ HIV/AIDS-related information		

<u>Signature(s)</u>

_____

Client (if age 13 or older) Date

If client is under the age of 18, please also complete the following:

_____

Print Parent/Guardian/Authorized Adult's Name Relation to Client

_____

Parent/Guardian/Authorized Adult Signature Date