DISCOVERY
Behavior Solutions

AUTHORIZATION TO RELEASE INFORMATION

This form is intended to provide authorization for the staff of Discovery Behavior Solutions LLC to review any necessary information, including Protected Health Information (PHI), and all related treatment records that may also include information related to Alcohol and/or Drug Use.

Client Information:

Client Name used in Treatment:
Date of Birth: Phone: Client ID #:
Address:

Information to be Released to and/or Received by:

☐ May RELEASE Information to and/or ☐ May RECEIVE information from
Name of Agency/Person:
Relationship/Role:
Address:
City: State: Zip Code:
Phone Number:
Fax Number:

Information Transmitted by *(note: information transmitted via fax & e-mail may contain potential limited confidentiality):*

☐ Phone ☐ E-mail ☐ Fax ☐ Snail mail ☐ Other (list):_____

Information Requested:

Please select the type of information to be released, shared and/or received

Only the following specific information about the client:

☐ Psychological/Psychiatric ☐ Medical ☐ Educational(IEP) ☐ Progress Notes

☐ Discharge Information ☐ Behavioral ☐ Developmental ☐ Diagnostic Report

☐ Initial Intake ☐ Treatment Plan ☐ Health Insurance Provider _____

☐ Specific health information including:_____

DISCOVERY
Behavior Solutions

☐ All health information about me, including my clinical records, created or received by the Provider, including my health information related to alcohol and/or drug use and related treatment records
Or

☐ All health information about me as described in the preceding checkbox(es), excluding (unless otherwise required by law): ☐ any information already received from a third party; ☐ any information pertaining to HIV/AIDS and/or sexually transmitted diseases; and/or the following: _____

Identify date range, if appropriate: Start Date: _____ through End Date: _____
(if no specific end date is indicated, this release of information will last one year from date signed, unless otherwise revoked.)

Purpose/why the Disclosures is Being Made:

(Please select one)
☐ The information being disclosed id for the purpose of:
☐ Continuity of Care between both named parties, including both written and verbal information.
☐ Other (please specify):
Expiration: ☐ This authorization expires at the end of my episode of care at Discovery Behavior Solutions LLC
OR:
(insert applicable event or date – mm/dd/yy):_____

Note: If an expiration event is used, the event must relate to the Client or the purpose of the use or disclosure. If the disclosure is to a financial institution or your employer for purposes other than payment, then this authorization expires in 60 days unless you renew it.

I understand that my records are protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164, as well as under RCW 70.02.030, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I have read and understand the terms of this Authorization. I understand that I am entitled to a copy of this Authorization after I sign it.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Client's Signature: _____ Date: _____
If the child is 12 years of age or younger or the adult is a Dependent, a Parent, legal Guardian, health care agent (proxy) or other representative is required.

Legal Guardian's signature (if required): _____ Date: _____

Print name: _____ Relationship to Client: _____