AUTHORIZATION FOR RELEASE OF MEDICAL, PSYCHOLOGICAL, DSHS AND VOCATIONAL INFORMATION

Patient Information: _____ **DOB**: _____

Information to be released from: _____

Information to be sent to:

☐ Me, _____, at the following address:

Address: _____

_____

☐ Please provide my records to the following person:

Name: _____

Address: _____

_____

I hereby waive any doctor-patient, psychological-patient, or counselor-patient privilege with respect to this request in favor of my attorneys.

Information to be released:
All records, opinions, reports, x-rays, or any other information or documents they may request regarding the above-named patient, as fully set forth in the letter enclosed with this authorization. Please carefully note limitations on dates of records and contents of records being requested that are fully set forth in the letter enclosed with this authorization.

Patient Authorization:
I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment of enrollment). I may revoke this authorization in writing to view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

EFFECT OF COPY: A COPY OF THIS AUTHORIZATION SHALL HAVE THE SAME FORCE AND EFFECT AS A SIGNED ORIGINAL. YOUR FULL COOPERATION WITH MY ATTORNEY IS REQUESTED.

SIGNATURE: _____ DATE:_____
(Patient, Guardian*, or Authorized Representative*)
(*Please provide documents to prove authority to sign on behalf of patient)

This Authorization will expire 180 days from the date signed.