THE EVERGREEN CLINIC
INTEGRATIVE PSYCHIATRY AND WELLNESS MEDICINE
13128 TOTEM LAKE BOULEVARD NE SUITE 206, KIRKLAND, WASHINGTON 98034
Main: 425 821 1810 **Fax:** 425 823 1231 **Intake:** 425 825 9644

RELEASE OF INFORMATION

Patient name: _____Date of birth: _____

Previous name**:** _____

I. **My Authorization**

You may use or disclose the following health care Information (check all that apply):

O All health care information in my medical record

O Health care information In my medical record relating to the following treatment or condition: _____

O Health care information in my medical record for the date(s): _____

O Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

O HIV (AIDS virus) **O** Sexually transmitted diseases

O Psychiatric disorders/mental health **O** Drug and/or alcohol use

Release Records from THE EVERGREEN CLINIC to:

_____
(Name)
_____
(Address)
_____
(City) **(State)** **(Zip)**
_____
(Phone) **(Fax)**

Release Records to THE EVERGREEN CLINIC from:

_____
(Name)
_____
(Address)
_____
(City) **(State)** **(Zip)**
_____
(Phone) **(Fax)**

Reason(s) for this authorization (check all that apply):

O at my request
O other (specify)
_____

O check only if [practice/facility] requests the authorization for marketing purposes
O check only if [practice/facility] will be paid or get something of value for providing health information for marketing purposes

This authorization ends: ***(This document does not permit disclosure of health information created more than 90 days alter date signed)***

O In 90 days from the date signed **O** on (date): _____

O when the following event occurs: _____
(No longer than 90 days from date signed)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by [name of practice or health care facility] based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from [practice/health care facility]; or
- Write a letter to [practice/health care facility].

Once health care Information is disclosed, the person or organization that receives It may re-disclose it Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)