PICACS CLINIC

10634 E Riverside Dr. Suite 130
Bothell, WA. 98011
Tel: (425) 806 5021
Fax: (425) 486 3949

AUTHORIZATION FOR RELEASE OF INFORMATION:

TO RECEIVE, USE OR RELEASEPROTECTED HEALTH INFORMATION

(Name of Patient)	(Date of Birth)
(Address)	(Signature of Patient or Legally Authorized Representative/ Guardian)

I, (the Patient or Legally Authorized Representative/ Guardian) hereby authorize
PICACS
to

☐ *RECEIVE FROM:* ☐ *TO RELEASE TO* *(Name of Individual/Agency*	(Address)
(Fax)	(Telephone)

I understand that this authorization extends to the following CONFIDENTIAL information/ records;

☐ Medical ☐ Psychiatric ☐ Intake/Discharge Note ☐ Chemical Dependency ☐ Psych Testing ☐ Therapy Notes ☐ Lab Tests

☐ Other Clinically Relevant Records, including _____

Purpose: To aid in the success of treatment and/or to provide continuity of care

Information to Use or Release: ☐ Talk with the provider
☐ Release all relevant health care information in my medical record.

If the ROI is addressed to a school/educator, I understand that the purpose of this request is to assist in planning an appropriate educational program for my child and that no other party except authorized school personnel shall have access to this information.

Please FAX/ MAIL/SEND
All relevant information at your earliest convenience
TO
THE ADDRESS/ FAX LISTED ABOVE

HIPAA Compliance

Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to coordinate health care, to seek insurance payment or to perform other specific health care procedures/services consented to by the patient.

1. **I understand that I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form:**
   - **To receive health care when the purpose is to create health care information for a third party.**
2. **I understand that if I revoked this authorization, it would not affect any actions already taken by the PICACS Clinic based upon this authorization, prior to it being revoked.**
3. **This authorization expires ☐90 days; ☐ 180 days; ☐ End of Treatment; ☐ by _____.**
4. **I understand that I can revoke this authorization at any time in writing.**

_____ _____

Signature (Patient/Guardian or Legally authorized Representative) Date