THE EVERGREEN CLINIC
12025 115th Ave NE, Suite 200 Kirkland, WA 98034
Main Line: 425.821.1810 / New Patient Intake Line: 425.825.9644 / Fax: 425.823.1231

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Patient's Name	Date of Birth
Previous or Alternate Name	

I authorize the use or disclosure of the following health care information (check all that apply):

- ☐ All healthcare information in the patient's medical record
- ☐ Healthcare information in the patient's medical record relating to the following treatment or condition:

_____

- ☐ Healthcare information in the patient's medical record for the dates from: _____ to: _____

Records to be released **from:**

Name (e.g. Insurance provider, Attorney, Physician, Patient, etc.)	Telephone #	Fax #	
Mailing Address	City	State	ZIP

Records to be released **to:**

Name (e.g. Insurance provider, Attorney, Physician, Patient, etc.)	Telephone #	Fax #	
Mailing Address	City	State	ZIP

Purpose of the request or disclosure of healthcare information:

- ☐ Per my request
- ☐ School requirement
- ☐ Transfer of care
- ☐ Legal
- ☐ Insurance provider
- ☐ Other: _____

I acknowledge that this authorization expires in one year, unless noted here: _____

1. I understand the information to be released or disclosed may include records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.
2. I understand my healthcare information/record contains information about my treatment and services I received through The Evergreen Clinic. My healthcare information/record is protected under State and Federal regulations
3. I do not have to sign this authorization in order to receive healthcare benefits (e.g. treatment, payment, or enrollment).
4. I may revoke this authorization in writing. If revoked, this would not affect any actions already taken by The Evergreen Clinic based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance
5. Once healthcare information is disclosed, the person or organization that receives it may not re-disclose this information without my written consent.
6. I understand that one of the federal privacy laws, the Health Insurance Portability and Accountability Act (HIPAA) has limited applicability and protects the disclosure of information by and between healthcare providers, health information clearinghouses, health plans, and health insurers. HIPAA does not protect the disclosure and possible re-disclosure of personal health information to individuals or organizations not covered by HIPAA. However, other federal and state laws do apply and will continue to protect my personal health information.

By signing this page, I acknowledge that I have read and agreed to the terms on this form.

Patient or Parent/Guardian Signature	Date

Printed name if signed on behalf of the Patient: _____
Relationship to Patient:
☐Parent ☐Guardian-Appointed ☐Guardian-Healthcare Power of Attorney ☐ Other: _____