

# INLAND NORTHWEST BEHAVIORAL HEALTH

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Maiden/Prior Names: \_\_\_\_\_ Current Phone #: \_\_\_\_\_  
Current Address: \_\_\_\_\_

**I am requesting disclosure of my protected health information for the following purpose:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Child Custody |
| <input type="checkbox"/> Academic        | <input type="checkbox"/> Legal Investigation      | <input type="checkbox"/> Other: _____  |

**Dates of Service Requested:** \_\_\_\_\_

**I authorize the release of the following:**

- |   |  |
|---|--|
| <input type="checkbox"/> Continuity of Care Packet -Discharge Plan Parts 1 and 2, Discharge Safety Plan, Medication Reconciliation, Advance Directives) | <input type="checkbox"/> Discharge Summary                           |
| <input type="checkbox"/> History and Physical   | <input type="checkbox"/> Psychiatric Evaluation                      |
| <input type="checkbox"/> Alcohol and Drug Abuse Treatment Records   | <input type="checkbox"/> Lab/Diagnostic Reports                      |
| <input type="checkbox"/> Physician's Orders   | <input type="checkbox"/> Progress Notes                              |
|   | <input type="checkbox"/> HIV Test Results and AIDS Treatment Records |
|   | <input type="checkbox"/> Other: _____                                |
|   | <input type="checkbox"/> Verbal Exchange of Information              |

**To be released by:**

Inland Behavioral Health  
 \_\_\_\_\_ ( ) \_\_\_\_\_  
Agency/Name Telephone Number Address City State Zip Code

**To be released to:**

\_\_\_\_\_ ( ) \_\_\_\_\_  
Agency/Name Telephone Number Address City State Zip Code  
( ) \_\_\_\_\_  
Fax Number

**This authorization will expire on \_\_\_/\_\_\_/20\_\_.** (If not indicated, authorization will expire six months from signature date)

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

\_\_\_\_\_  
Revocation Signature Date/Time

**This form must be completed in full before signing:**

\_\_\_\_\_  
Patient's signature (required for ages 12 and older) Parent/Legal Guardian signature (if applicable) Relationship to Patient

\_\_\_\_\_  
Witness signature/Credentials Date Signed

This authorization is intended to allow **Inland Northwest Behavioral Health** to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.