**SENDAN CENTER**
4201 Meridian St, Suite 113 Bellingham, WA 98226
tel 360-305-3275 fax 360-734-5503 www.sendancenter.com

# AUTHORIZATION FOR RELEASE OF INFORMATION

Patient name: _____ Date of birth: _____ Prior name: _____

**I. My Authorization**

**Under this authorization, all clinicians and service professionals at Sendan Center may mutually exchange my health care information, by phone, fax, email or postal mail, with:**

_____
Name Title Organization Department

Contact information (address, phone number, fax or email): _____

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

- ☐ All information concerning my treatment.
- ☐ Records from date: _____ to _____.
- ☐ Summary of Sendan Center treatment and assessment.
- ☐ Ongoing communication regarding my care here and with the individual/organization listed above.
- ☐ Communication regarding the school setting, Individual Education Plan (IEP) or section 504 accommodations, and psycho-educational testing
- ☐ Other: _____

**The purpose of the authorized disclosure is:** _____

**You must indicate that you allow the release of the following (please check all that you approve):**

- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use
- ☐ Sexually transmitted diseases
- ☐ HIV (AIDS virus)

I understand that my alcohol and / or drug treatment records are protected under the Federal and State regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by such regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as described below.

Without my express revocation, the authorization will automatically expire after 90 days of treatment termination unless otherwise specified or under the following condition(s):

_____

**II. My Rights**

I understand that I must give my written permission for any medical information concerning myself/my child to be released. I understand that I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Sendan Center staff, based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance payment. To revoke this authorization, I must complete a cancellation form available from Sendan Center.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Potential for Redisclosure: Once this information is released Sendan Center has no control over it. Redisclosure of my medical records by recipients of the above authorized information may occur without my further written authorization and may no longer be protected by Privacy laws.

You may request a copy of this document, or one may be available via your electronic medical record.

_____
Patient signature (if 13 years of age or older) Date Time

_____
Parent or legally authorized individual signature Date Time

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