The Steven A. Cohen Military Family Clinic at Valley Cities

RELEASE OF INFORMATION

Return to:
Medical Records
6103 Mount Tacoma Drive
Lakewood, WA 98499

Phone: 253-215-7070
Fax: 253-584-1923
Hours:
Mon – Th: 8:30am-5pm
Friday: 8:30am -3pm

Client Information

Name (please print full legal name): _____ Date of Birth: _____

Address: _____ Phone number: _____

Request information from the listed person/ organization:

Name of Person/ Organization: _____

Phone: _____ Email: _____ Fax: _____

Address: _____

Disclose my information to the listed person/ organization:

Name of Person/ Organization: _____

Phone: _____ Email: _____ Fax: _____

Address: _____

☐**All Mental Health Records**

☐**All Mental Health Financial/Billing Records**

Or

Specific Dates of Service:

From_____ To_____

(*Most recent 1 year of records is the default if no dates are selected.*)

If ***ALL RECORDS*** are ***NOT*** needed, ***ONLY*** check items below:

☐Assessment(s)/Update(s)	☐Psychiatric Evaluation	☐Individual Treatment
☐Crisis Plan	☐Psychiatric or Medical Notes	☐Group Treatment
☐Treatment Plan(s)	☐Active Medications	☐Family Treatment
☐Scheduling/Appointment History	☐Active Problem List (Diagnoses)	☐Peer Services
☐Discharge Summary(s):	☐Laboratory Reports/Results	☐Case Management/Community Support

☐Other (specify): _____

SIGNATURE REQUIRED ON PAGE 2

Expiration: *Unless otherwise specified, the ROI will <u>automatically</u> default to expire on the date of discharge

<u>Only</u> select if needed:

☐ Upon one-time release of the above information

☐ On this date: _____

I understand that:

- Only the person who has consented for care (including minors 13 years of age and older) can authorize for release of record. (RCW 70.02.10 and RCW 71.34.530). Any person who is a legal representative or durable power of attorney for the client must provide legal documentation (RCW 11.125.050).
- This authorization is my consent that allows the Cohen Clinic at Valley Cities to disclose information about my healthcare, mental health, substance use treatment, HIV/AIDS, and sexually transmitted diseases. These records are protected by state and federal law (RCW 70.02, RCW 70.24, 42 CFR Part 2, 45 CFR Parts 160 & 164) and cannot be shared without my written consent, except as permitted by law.
- I may cancel this authorization at any time, except to the extent that action has already been taken. To revoke authorization to release Mental Health information, I must do so in writing.
- I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).
- It is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by Federal Privacy Standards.

Signature:

Client/ Legal Authority Signature: _____ **Date:** _____

Written Name of Client/Legal Authority: _____

If the authorization is signed by a Legal Authority of the individual, a description of such representative's authority to act for the individual must also be provided.

Relationship to Client: _____

Description of Legal Authority: _____

SIGNATURE REQUIRED ABOVE

REVOCATION

You may revoke this authorization in writing. You may visit the Cohen Clinic at Valley Cities in person or obtain the Revocation form at https://cohen.valleycities.org/medical-records/. The revocation will be effective upon receipt and approval. Any information that has already been released or services already provided according to this authorization will not apply.