ICARD PLLC

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(509) 838-3932 phone (509) 838-1163 fax

RELEASE OF INFORMATION

CLIENT NAME:

Name			Date of Birth
Address	City	State	Zip Code
Phone	Phone		

AUTHORIZATION TO DISCLOSE:

I consent to the use of confidential information about me with ICARD, PLLC to plan, provide and coordinate treatment, payments, and benefits for me or for other purposes authorized by law. I further grant permission to ICARD, PLLC and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for purposes associated with my treatment and care. Information may be shared in person, by phone, verbally or by computer data transfer, fax, mail or hand delivery.

Name of Individual Person, Provider, Facility or School			
Address	City	State	Zip Code
Phone	Fax		

I authorize and consent to sharing the following information (check all that apply):

☐ Request health information from ☐ Discuss health information with ☐ Send health information to

PURPOSE: ☐ **Treatment Coordination** ☐ **Psychological Evaluation** ☐ **Other** _____

☐ Treatment Summary ☐ Diagnostic Verification ☐ Assessments
☐ Treatment Plan(s) ☐ **All personal health information (PHI)**

☐ Specific information: _____

AUTHORIZATION

Printed Name of Client	
Signature of Client	Date

Printed Name Authorized Representative (Parent, Legal Guardian, Personal Representative)	Relationship to Client
Signature of Authorized Representative (Parent or Legal Guardian)	Date

If the individual is twelve (12) years of age or younger, or the adult is a dependent; a parent, legal guardian or personal representative is required to sign above.

This authorization will expire <u>one year</u> from the date of signature unless otherwise noted. Exp date: _____

RECORDS WITH ADDITIONAL PROTECTIONS: If your records include any of the following information, you must also complete this section to include these records. I give my permission to disclose the following records (check all that apply):

☐ **Mental Health** ☐ HIV/AIDS and/or STD records, diagnosis or treatment ☐ Chemical dependency or substance use

Health information is protected under federal regulations governing confidentiality, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, as well as subsets under state RCW 70.02, RCW 71.05, RCW 71.34, WAC 388-865 and WAC 388-877.

- This authorization is effective for the above requested and authorized health care information only. A copy of this form is valid to give my permission to disclose records.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this clinic or caretaker. Your revocation will be honored except that has been acted on in good faith while in force. The information you are authorizing to be released could be re-released or disclosed by the recipient. We are not responsible for the actions of others who may be provided with information released as a result of this authorization. You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent the information being requested may assist your health care provider in determining appropriate treatment.

Notice to Client: Unless otherwise specified by law, we will release only that information which has been created by this entity. Records created by and provided to this office from other entities must be obtained directly from those other providers or facilities. There may be a fee associated with copying of your records. You are entitled to review your personal health information record from this office. Please ask for additional information about our Privacy Policy and how ICARD, PLLC safeguards your privacy.

Notice to Recipients of Information: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.