



This form authorizes the release of your health information. You control what is released, to whom, and for how long. You may revoke this authorization at any time in writing. Signing is voluntary; it does not affect your treatment.

1 PATIENT INFORMATION

Patient Full Name	Date of Birth (MM/DD/YYYY)	Last 4 SSN (optional)	Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient Address	City	State	ZIP
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2 DIRECTION OF RELEASE (CHECK ONE)

- RELEASE TO: Authorize this practice to RELEASE information TO the individual/organization below
- OBTAIN FROM: Authorize this practice to OBTAIN information FROM the individual/organization below

3 OTHER PARTY (WHO RECEIVES OR PROVIDES INFORMATION)

Name of Individual or Organization	Attention / Dept.
<input type="text"/>	<input type="text"/>
Address	City State ZIP
<input type="text"/>	<input type="text"/>
Phone	Fax
<input type="text"/>	<input type="text"/>
	Email (if secure)
<input type="text"/>	<input type="text"/>

4 INFORMATION TO BE RELEASED / OBTAINED

Check all that apply:

- Psychiatric evaluation(s) and consultation notes
- Psychotherapy notes / progress notes
- Medication records (list of medications, prescribing history)
- Laboratory results
- Discharge summary
- Treatment plan
- Substance use disorder treatment records (also requires 42 CFR Part 2 consent — see Form 5)
- HIV/AIDS-related information (requires specific authorization under RCW 70.02.220)
- Records pertaining to dates of service: From: _____ To: _____
- Complete medical record



Other (specify):

5 PURPOSE OF RELEASE / REQUEST

- Continuing medical care / care coordination
- Second opinion or specialist consultation
- Personal use by patient / family
- Legal proceedings (specify below)
- Insurance / disability evaluation
- School or educational records

Other purpose (specify):

6 EXPIRATION

This authorization expires on (check one):

- Specific date: _____
- Upon occurrence of event: _____
- One (1) year from the date I sign below
- Upon completion of the stated purpose

