Couple & Family Institute of Tri-Cities

8121 W . Quinault Ave. Suite F202
Kennewick, W A 99336
509-579-0200 Office

Release Of Information

I, _____ (DOB),____ _, give permission for _____ on _____ _
(Name of Client) (Name of Provider) (Date)

INITIAL APPROPRIATE RESPONSE	INSTITUTION, AGENCY OR PERSON
_____To disclose to: _____To exchange with: _____To receive the following information from:	Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax _____

INFORMATION REQUESTED: (Initial appropriate boxes)

☐Chart Notes	☐Psychiatric Admit Note	☐Inpatient Records
☐Consultation reports	☐Summary of Progress	☐Outpatient Records
☐Crisis Response Records	☐Treatment Plan	☐Psychological Report
☐Psychosocial Assessment	☐Medication Record	☐Radiology
☐Psychiatric Evaluation	☐Laboratory Reports	☐History and Physical
☐Termination Summary	☐Psychological Assessment/testing	☐Substance Abuse Records

Other (Please Specify): _____ _

You may use or disclose information health care information regarding testing, diagnosis, and treatment for (initial all that apply)

__ Mental Health __ Drug and Alcohol Abuse or Treatment
____ HIV/AIDS __ Sexually Transmitted Diseases

This authorization ends:

(date):------- ☐ when the following event occurs: _____ _

II. My Rights

- I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health care information for a third party.
- I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Couple & Family Institute ofTri-Cities (CFID and other providers at the 8121 W. Quinault Ave Suite F202 location based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
- Fill out a revocation form. A form is available from CFiT, Or Write a letter to CFiT.
- Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.
- I understand there may be charges associated with my request for records. Such charges shall not exceed the amount allowable under RCW 70.02.
- Any minor child thirteen (13) years or older has the same rights as an adult to voluntarily seek treatment and must give written consent for records to be released to others, including parents. Therefore, minor clients must sign authorization for us to release that client information within the statutes of the law.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, etc)