

UNITED FAMILY CENTER

AUTHORIZATION TO RELEASE INFORMATION

Client's Last Name _____ First Name _____ M.I. _____ Date of Birth _____
(Please print)

I hereby authorize **United Family Center** 211 Euclid St.
Grandview, WA. 98930
Ph. 509.402.9090
Fax. 509.516.0062

to ☐ obtain, ☐ disclose, and ☐ send information to: _____

Relation/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____

for the purpose of ☐ **Evaluation and treatment planning** ☐ **Determining eligibility for programs**
☐ **Continuity of Care** ☐ **Other:** _____

This request and authorization apply to (check items):

- | | |
|--|---|
| ☐ All Mental Health Records | ☐ All Substance Use Records/History |
| ☐ Intake Assessment(s) | ☐ Substance Use Assessment(s) |
| ☐ Therapist Notes | ☐ Medical History, Evaluation, and Discharge Summary |
| ☐ Treatment Plans | ☐ Medications and related information |
| ☐ Discharge Summary | ☐ Developmental and Social History |
| ☐ All Educational Records | ☐ Other (Specify): _____ |

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year or on (Date) _____ this consent will automatically expire. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Delivery Instructions: Secured email, mail, fax, and telephone. I have been provided a copy of this form.

(If the consumer is 12 years of age or younger or is an adult with a court-appointed guardian, this release must be signed by the consumer's parent or guardian.)

Client Name: _____ Signature: _____ Date: _____

Witness Signature (if client is unable to sign): _____ Date: _____

Parent/Guardian Name: _____ Signature: _____ Date: _____