LIFEWORKS NW

ROIA_____REC/SIGN DATE:_____

Authorization to Use and Disclose Protected Health Information

This authorization must be written, dated and signed by the consumer or by a person authorized by law.

Client Name: _____ **Date of Birth:** _____

1. Person/Organization_____ **Phone**_____

Address_____ **Fax**_____

Email_____

2. I authorize LifeWorks NW to: ☐ Both Release and Receive Information ☐ Release Information Only ☐ Receive Information Only

3. Information will be used on my behalf for the following purpose(s) (check all that apply):

☐ Evaluation ☐ Monitoring
☐ Treatment planning ☐ Treatment referral
☐ Coordination of care ☐ All of the above

If this authorization will be used for additional or more limited purposes, please describe here:

4. LifeWorks NW is a behavioral health care organization specializing in the prevention, evaluation and treatment of mental health and alcohol and drug conditions. We do not use or disclose any genetic testing information.

By initialing on the spaces below, I specifically authorize the release of the following medical/mental health records.

►_____ Disclose alcohol and drug information (Initial here) ►_____ Disclose mental health and/or medication information (Initial here)

►_____ Disclose HIV/AIDS information (Initial here) ►_____ Other specific information: _____ (Initial here)

List any specific information you **DO NOT** want disclosed: _____

5. Federal or state law may require that HIV/AIDS, mental health, drug/alcohol or genetic testing information not be re-disclosed. It is possible, however, that the person or organization who receives the information may re-disclose it. The information being shared will be the minimum amount necessary to accomplish the purpose of this authorization. I understand that this information may be shared via phone, fax, mail, email, in written form, or in person. LifeWorks NW does not require that I sign this authorization. Refusal to sign this will not affect my ability to access health services.

6. I understand that I may revoke (i.e., take back) this authorization either in writing or verbally at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described on this form. If LifeWorks NW already used or disclosed information because of this authorization, that cannot be undone.

****Unless revoked, this authorization will remain in effect for the duration of my treatment at LifeWorks NW or until:** _____.

7. I have read this authorization and understand it.

_____ _____
(Date) (Signature of client/guardian)

_____ _____
(Relationship to client if signed by guardian) (Reason client is unable to sign)

****This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal regulation also restricts any use of the information to criminally investigate or prosecute the patient.** https://lifeworksnw.sharepoint.com/Clinical/Shared Documents/Release of Information 2017.pdf