Wellfound
Behavioral Health Hospital

Release of Information
Authorization to Use or Disclose

3402 South 19th Street, Tacoma, WA 98405
HIM Phone: 253-301-5447
HIM Fax: 253-301-5446

I authorize WBHH to:

◯ Exchange information with:
◯ Send my medical records to:
◯ Request records from:

Name of Individual / Entity: _____

Relationship to Patient: _____

Address: _____

Phone: _____ Fax: _____

*Must list **COMPLETE** address and phone/fax number (this **INCLUDES** requests for VERBAL exchanges)

Information to be released is regarding MYSELF unless:

◯ Patient for whom I am POA, DPOA or legal representative

*Write the RELATIONSHIP to the patient if YOU ARE NOT the patient: _____

Purpose of Release is for CONTINUITY OF CARE unless otherwise specified:

◯ Facilitate Treatment Planning
◯ Condition of Court Order / Parole
◯ Enable Transfer of Services
◯ Other: _____

Type of information to be disclosed (Describe as detailed as possible):

_____

Information that may <u>NOT</u> be disclosed: ◯ Substance Use Disorder ◯ HIV/STD ◯ Other: _____

- **I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.**
- **I understand that the information released is confidential and must be used for the purpose that it was requested for; however, once this information is disclosed, the information may be subject to redisclosure. The redisclosing entity is responsible for following the confidentiality laws for redisclosing the information.**
- **I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Wellfound Behavioral Health Hospital. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.**
- **I understand authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment or payment, on my behalf unless an authorization for disclosure is required for Wellfound Behavioral Health Hospital to receive third party payment for services rendered.**

I understand that there may be a fee charged for copies of my records as set by WAC 246-08-400.

This authorization **EXPIRES 60 DAYS** after termination of services at WBBH, otherwise **EXPIRES**: _____

Signature (Patient or legal representative): _____ Date: _____

Print Patient Name: _____ DOB: _____

Revision date: 10/31/2019

Patient Label Here