Wellfound
Behavioral Health Hospital

3402 S 19th Street Tacoma, WA 98405

Release of Information
Authorization to Use or Disclose

Phone: 253-301-5447 Fax: 253-301-5446

I authorize Wellfound Behavioral Health Hospital (WBHH) to:

◯ Exchange information with (write below): ◯ Send my medical records (write below): ◯ Request records from (write below):

Release format: ◯ Verbal/Oral discussions ◯ Paper Copy - pick up/mail ◯ Fax ◯ Electronic (CD)

Name of Individual / Entity: _____

Attn/Dept.: _____ Relationship to Patient: _____

Address: _____

Phone #: _____ Fax #: _____

*Must list **COMPLETE** name, address, and phone/fax # for records (VERBAL exchanges must list **COMPLETE** name and phone #)

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

◯ Facilitate Treatment Planning ◯ Enable Transfer of Services

◯ Condition of Court Order/Parole ◯ Other: _____

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

◯ Entire Medical Record ◯ Discharge Summary ◯ Lab Results

◯ Admission Assessments ◯ Progress Notes ◯ Imaging Results

◯ Psychological Assessments ◯ Other: _____

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.**
- **A copy or fax of this document shall be considered valid in lieu of the original.**

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

This authorization **EXPIRES 1 YEAR** from the date of signature, or otherwise **EXPIRES**: _____

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

Print Patient Name: _____ Date of Birth (DOB): _____

Patient Label Here

Rev. 08/31/2023