Wellfound
Behavioral Health Hospital

# Release of Information (ROI) Authorization

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

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

**I authorize Wellfound Behavioral Health Hospital (WBHH) to have my information and/or medical records be:** (check box)

◯ Verbally Exchanged and Discussed (written below): ◯ Send To (written below): ◯ Requested From (written below):

**Release format** (if applicable)**:** ◯ Paper Copy - pick up/mail ◯ Fax ◯ Electronic (CD)

Name of Individual / Organization: _____

Attn/Dept.: _____ Relationship to Patient: _____

Address: _____ City, State, Zip Code: _____

Phone #: _____ Fax #: _____

*Must list **COMPLETE** name and phone # for verbal exchanges. / Must list **COMPLETE** name, address, phone #, and fax # (if applicable) for records.

**Purpose for Release is CONTINUITY OF CARE unless otherwise specified** (write in): _____

**Type of Information to be Disclosed (describe as detailed as possible):**

| | | | |
|---|---|---|---|
| **Verbally:** | ◯ All Information about my Treatment History and Care | ◯ Summary of Information within my Medical Record | |
| | ◯ Admission Status | ◯ Discharge Planning | |
| | ◯ Collateral Information | ◯ Other (please specify): _____ | |
| **Records:** | ◯ Entire Medical Record | ◯ Discharge Summary | ◯ Lab Results |
| | ◯ Admission Assessments | ◯ Progress Notes | ◯ Imaging Results |
| | ◯ Psychological Assessments | ◯ Other (please specify): _____ | |

**Information that may <u>NOT</u> be disclosed:** ◯ Substance Use Disorder (SUD) ◯ 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 WBHH. 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 WBHH 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.

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

**Signature:**

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

Legal Representative (if signed above):

Print Name: _____ Relationship to Patient: _____

Patient Label Here